ADULT PERFORMANCE OUTCOME SYSTEM

CLINICAL TRAINING MANUAL

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CHAPTER 1
WHY PERFORMANCE OUTCOMES?

National Trends

In response to initiatives and discussions at national, state, and local levels, there is increasing interest in developing and implementing measures of system and client-level outcomes. National organizations, state mental health agencies, and county mental health authorities are currently in the process of developing and implementing mental health performance outcome measurement systems to ensure accountability for the expenditure of public behavioral healthcare dollars and for ensuring high quality and effective care to mental health consumers. As indicated in the following excerpts, performance outcome measurements are becoming an increasingly important tool in making service-related decisions in the public mental health system.

> "The demand for accountability has been pressing against the doors of mental healthcare organizations and independent practitioners for over a decade. The fast emerging age of managed care and universal healthcare has intensified the demand for accountability. It is now very real and the doors have been opened. State legislatures, the United States Congress, private payers, and consumers now routinely ask questions about the necessity and quality of mental health services (Goodman, Brown, & Deitz, 1992; Mintz & Kiesler, 1982). As a result, the mental healthcare profession has entered an era of scrutiny never before experienced. To the practitioner who states that clinical needs and outcomes are too subjective to measure and quantify, payers are posed to respond in this manner: 'Then they also may well be too subjective to pay for (Brown, 1991).'"[1]

> "With pressures all around for accountability in healthcare services, implementing strategies for measuring and reporting outcomes has become a way of life for providers. And in the psychiatric specialty field, proving need and value generally has been far more difficult than in the more physical areas. However, that has begun to change, as there are greater data gathering and sorting capabilities now than ever before. Sophisticated outcomes measurement and research in psychiatric care is gearing up to change the relationship with its payers."[2]

Efforts toward performance measurement on the national level include, among others, the Mental Health Statistics Improvement Program (MHSIP), Performance Measures for Managed Behavioral Healthcare Programs (PERMS), and Candidate Indicators for County Performance Outcomes. Table 1-1 summarizes the proposed domains and measures for each of these national programs currently under development.

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[1] Green, M. (1996) In Quest of Outcomes: the Larimer Project. Community Mental Health Journal 32(1), 11-21.

[2] Smith, J. (1993) Measuring an Inexact Science. Health Systems Review, 6-10.

TABLE 1-1: National Performance Outcome Systems in Development

National Program	Domains	Measures
MHSIP is a collaborative and cooperative venture between the Federal Government and the States to work towards achieving program, management, and performance monitoring improvement through the use of data. MHSIP provides guidance and technical assistance regarding mental health information systems, promotes uniformity through standards, and facilitates meaningful comparisons of costs, performance and services.	The MHSIP Report Card, a consumer-centered managed care report card, covers the general domains of access, quality and appropriateness, promotion/ prevention and outcomes.	The MHSIP Report Card's proposed measures include speed and access to services, Affordability, parity of coverage, consumer access to information, absence of cultural barrier, consumer health, quality of life, reduction in psychological stress, and consumer productivity and independence.
The American Managed Behavioral Healthcare Association, representing private managed behavioral healthcare providers on a national level, has field-tested PERMS 1.0 utilizing data collected from MediCal records, administrative data and client surveys.	PERMS organizes performance measures into access, consumer satisfaction and quality of care domains.	PERMS includes measures of service utilization, cost, penetration rates, call abandonment rates, and consumer satisfaction with access to clinical care, efficiency, and effectiveness.
Candidate Indicators for County Performance Outcomes are being developed by the Evaluation Center @ HSRI under a contract with the National Association of County Behavioral Healthcare Directors (NACBHD).	The NACBHD's proposed system includes access, consumer satisfaction, consumer outcomes, intersystem outcomes, and utilization domains.	Individual indications and measures of service include: level of staff cultural competence; location; speed, ease and timeliness; consumer satisfaction with comprehensiveness; integration of services with social supports; symptom management and level of wellness; level of independence; self-reliance and self esteem; level of consumer involvement in work, school, social and family relationships, contacts with other community providers; use of hospital care; and cost of services.

At the state level, performance measures are being developed in states that have, as well as those that have not, introduced managed care reforms. Serious efforts have been underway for a number of years to develop system and client measures to facilitate monitoring of contracts and to assist in continuous quality improvement. Approximately half of the states in the country have developed, or are in the process of developing, report cards or performance outcome measurement systems.

Realignment Legislation

For many years, mental health funding in California was on a fiscal roller coaster, subject to the vagaries of the state budget. In 1991, legislation referred to as "realignment" (Chapter 89, Statutes of 1991, also known as the Bronzan-McCorquodale Act) created a more stable funding source by earmarking a certain percentage of the sales tax and vehicle license fees for county mental health funding. Realignment legislation also specifies the maintenance and oversight of a public mental health service system for a target population of persons who are seriously mentally ill which is "client-centered, culturally competent, and fully accountable". The legislation requires the development of a uniform, statewide client-based information system that includes performance outcome measures.

Realignment legislation requires that all counties report data on performance outcome measures to the State Department of Mental Health (DMH) which, in turn, is to make those data available to the California Legislature, local mental health boards and commissions, and the California Mental Health Planning Council (CMHPC).

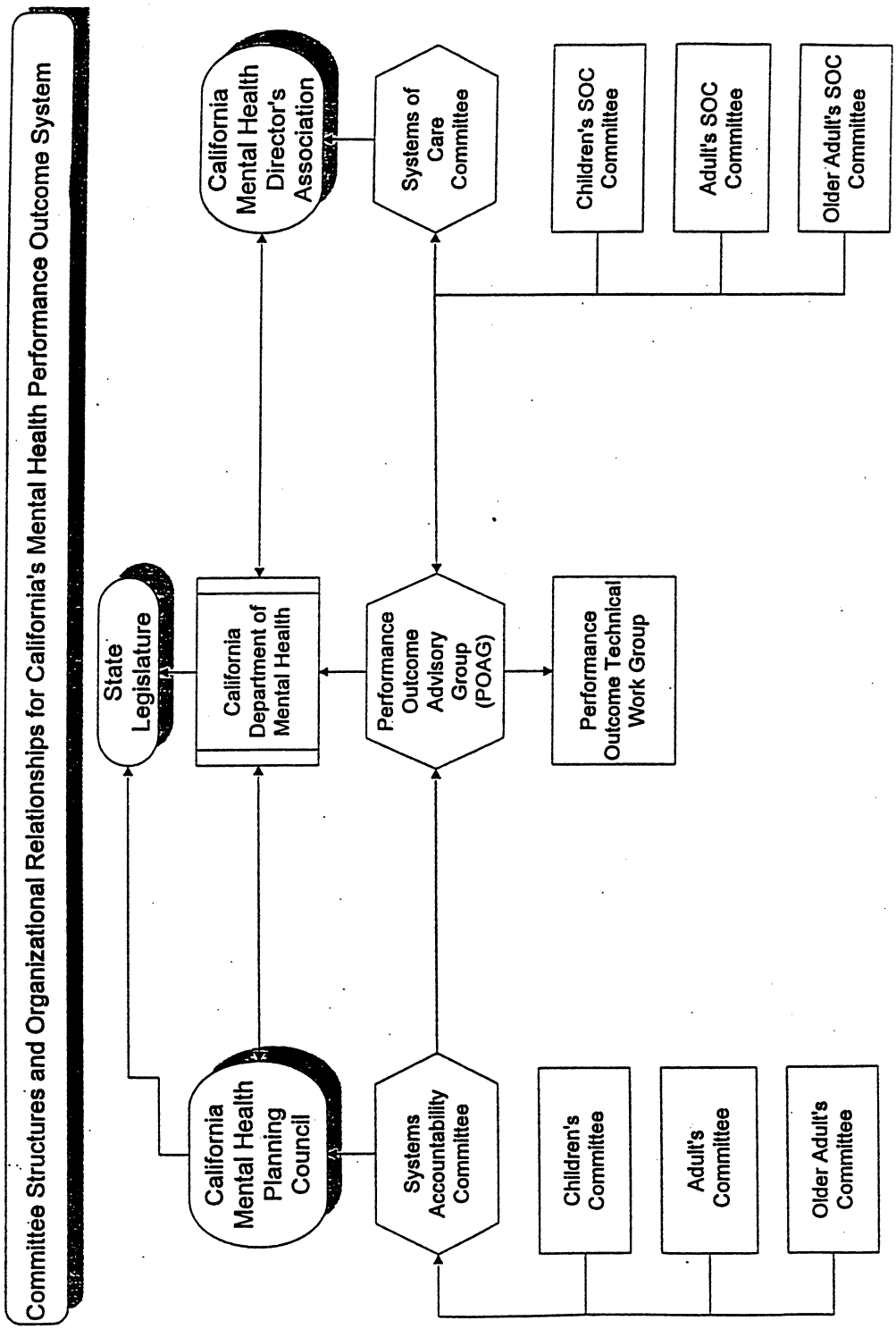
Collaborative Process

The California Mental Health Directors Association (CMHDA), the CMHPC, and the DMH have collaborated on every step of the process for developing California's mental health performance outcome system. Figure 1-1 provides a graphical representation of how the CMHDA, CMHPC, and DMH participated together in the planning process.

The central feature of the process was the Performance Outcome Advisory Group (POAG). The POAG was comprised of members drawn from the CMHDA, CMHPC, DMH, direct consumers, family members, and representatives of advocacy groups. The POAG, which was a policy level work group, reviewed recommendations from the Performance Outcome Technical Work Group (POTWG) and made recommendations to DMH for final decision. The POTWG was composed of some members of the POAG as well as other individuals with specific clinical, policy, fiscal or data management expertise. The work group was co-chaired by the DMH, CMHDA, and CMHPC and all interested parties were welcome to attend workgroup meetings. Together, these groups attempted to represent a balanced voice from all of the major constituencies. Their recommendations were presented to the DMH which, upon considering the issue from the State perspective, made informed policy decisions.

Once the POAG had completed its function (laying the groundwork for the outcomes implementation process), the group was disbanded. For the next phase, which will concentrate on quality improvement and integrating outcomes and overall system oversight into a seamless system, a new group will be formed, again composed of representatives of the CMHDA, CMHPC, DMH, and the community of mental health consumers and family members.

FIGURE 1-1


Committee Structures and Organizational Relationships for California's Mental Health Performance Outcome System
California Mental Health Director's Association
Systems of Care Committee
Children's SOC Committee
Adult's SOC Committee
Older Adult's SOC Committee
State Legislature
California Department of Mental Health
Performance Outcome Advisory Group (POAG)
Performance Outcome Technical Work Group
California Mental Health Planning Council
Systems Accountability Committee
Children's Committee
Adult's Committee
Older Adult's Committee

Development of Adult Performance Outcome Measurement System

Previous Adult Performance Outcome Efforts. The first attempt at collecting performance outcome data was based on a custom-designed survey, the Adult Performance Outcome Survey (APOS), developed by DMH in conjunction with county and consumer representatives. This custom survey was designed to be administered to a sample of seriously mentally ill (SMI) adult clients at a beginning time, six months later, and then again one year later. Several issues that emerged during this study included the difficulties of maintaining a representative sample and the lack of comparability of the data. Maintaining a representative sample became increasingly difficult as clients would drop out of service, move out of the area, or disappear for other reasons. In order to keep the sample representative, county staff had to spend time looking for these individuals which was time-consuming and not particularly cost-effective. Additionally, since the custom-designed survey was only administered to a sample population, clinicians administering the survey found it to be more of an additional paperwork burden than the collection of data useful for treatment planning. And, since the survey was custom-designed and not a standardized instrument, the data were not comparable to data from other states or entities. Comparability of data is becoming increasingly important in an era of national focus on performance measures.

Based upon the results from the APOS, the CMHDA, CMHPC, and DMH established several criteria for future studies. These criteria include recommendations that the data should:

- be useful to clinicians for treatment planning;
- be useful to counties for quality management purposes;
- meet the requirements of the state for performance outcome data; and
- allow comparison of California's public mental health programs with those of other states/entities.

Adult Performance Outcome Pilot. Under the leadership of DMH, and in collaboration with the CMHPC and the CMHDA, nine counties volunteered to participate in a pilot project to assess several instruments for use in the implementation of an adult performance outcome system in California. The pilot counties were: Los Angeles, San Francisco, San Joaquin, San Mateo, Santa Barbara, Stanislaus, Tehama, Tulare, and Ventura. The piloted instruments were evaluated on administrative, psychometric, and qualitative factors. In addition, discussions were held regarding the minimum set of instruments necessary to adequately measure several important quality of life domains. Pilot counties also evaluated the automated or manual data entry/scoring systems they used to report performance outcome data to clinicians, county management, and DMH.

Each pilot county administered a selection of the assessment instruments to a sample of the target population (seriously mentally ill clients, expected to be in service more than 60 days) at time one and then again six months later. Each county then forwarded its pilot data to the DMH for analysis, along with an evaluative report. The report described their sample of clients; the training, selection, and administration procedures used; and provided narrative evaluations of the instruments and data collection/scoring system used. Qualitative evaluations of instruments included: time to administer and score, clinical usefulness of the data generated, usefulness of the data for quality improvement or program evaluation, cultural competence of the instrument, and acceptability to consumers and/or family members. Qualitative evaluations of data information systems included cost of the system, optimal system requirements, ease of the system to set up and use, stability of the system, and customer service and technical support from the developers of the system.

Recommendation. Using a collaborative process, taking into account the adult pilot results as well as other factors, the POAG recommended the following set of instruments for the Adult Performance Outcome System:

- the Global Assessment of Functioning *(GAF*)
- the Behavior and Symptom Identification Scale (*BASIS-32)*
- a quality of life instrument (**either** the California Quality of Life (*CA-QOL)* **or** Lehman's Quality of Life - Short Form (*QL-SF*)
- the Mental Health Statistics Improvement Program (*MHSIP*) Consumer Survey - (26-item version)

Refer to page 2-1 for a description of each adult performance outcome instrument.

Usefulness to Clinicians

The data generated by the instruments are intended to provide clinicians with a multi-axial or multi-source method of collecting client-relevant data. This information may be used by the clinician to identify specific target areas that are most affecting the client's life and to select appropriate intervention techniques. Additionally, the clinician can evaluate the outcomes of the services he or she provides either to the same client over time or to specific sub-populations of the clients he or she serves. Typically, the data may be used by the clinicians to both supplement and cross-validate their own clinical judgments.

Frequently Asked Questions

- Why is it important that counties and the State measure mental health performance outcomes?

  There are several reasons why measuring and reporting performance outcomes is important. The first reason for collecting outcome data is to ensure that public mental health programs are accountable for the expenditure of public funds. This is a predominant feature of Realignment, the legislation that mandated performance outcomes. Secondly, the emergence of managed care is making it increasingly important that public mental health programs be able to demonstrate that their programs are cost-effective, while ensuring that client access to high quality and effective services is maintained. The federal government is also requiring states to produce outcome information to justify continuation of federal funds. Monitoring performance via outcomes as opposed to process is the approach adopted nationally by both the public and private health care sectors.

- Is it possible to change the current methodology for the Adult Performance Outcome System?

  Not at this time. The CMHPC, CMHDA, and the DMH have agreed to proceed with this system to come into compliance with legislation. However, the CMHPC, CMHDA, and DMH are committed to a continual process of evolution of the system and will be examining potentially more cost-effective and efficient instruments and methodologies.

CHAPTER 2
OVERVIEW OF THE
ADULT PERFORMANCE OUTCOME SYSTEM

Adult Performance Outcome Instruments

TABLE 2-1: Brief Description of Adult Performance Outcome Instruments

Required Adult Performance Outcome Instruments:
Global Assessment of Functioning (GAF): • clinician-rated scale indicating a client's general level of functioning on a continuum from 1 to 100 (mental illness to mental health) • a single score incorporates role performance, symptomatology, and behavioral functioning
Behavior and Symptom Identification Scale (BASIS-32): • 32-item inventory measuring behavioral functioning and symptomatology from the consumer's perspective • results can be scored into five domains (i.e., relation to self and others, depression/anxiety, daily living skills, impulsive/addictive, psychosis) and an overall average • subscale profiles are available
One* of the following Quality of Life Instruments:** ***California Quality of Life (CA-QOL)* • 40-item quality of life instrument using items extracted from Lehman's Quality of Life-Brief Interview (*QOL-B*) • consists of 16 objective items and 24 subjective items • when supplemented by the DMH CSI data system, measures all *QOL-B*'s objective scales (living situation, productive activities, family/social contacts, finances, victim, arrests, general health) and subjective scales (satisfaction with: living situation, leisure activities, daily activities, family and social relationships, finance, safety, health, and general life). ***Lehman's Quality of Life - Short Form (QL-SF)**** • 38-item quality of life instrument, developed statistically from the *QOL-B* • consists of 28 objective items and ten subjective items • measures all *QOL-B* scales (see scales listed under *CA-QOL* above) ***Note:** scale scores on the two quality of life instruments can be statistically equated.*
Mental Health Statistics Improvement Program (MHSIP) Consumer Survey-Short Form • 26-item consumer satisfaction survey developed from the longer 40-item *MHSIP* Consumer Survey

All instruments, except for the *GAF*, are intended to be self-administered; however, some clients in the target population may need assistance.

Ordering Instrument Forms

The instrument forms are available in a variety of formats from different sources depending upon the type of input methodology. DMH, in their contacts with county programs, have found three major data input measures are being used. These include hand entry of data, the TELEform fax-based system, and the HCIA Response card reader system (see Chapter 11, page 11-26 for information on other technologies). Costs will vary depending on the format selected. **Be sure to order the correct format of the instrument forms based on the technology being used for data input**. Small counties (less than 50,000 in population) are eligible to use a centralized TELE*form* system located at DMH to fax in instrument data. Small counties that elect to use this system would need to procure forms in the TELE*form* format.

Table 2-2: Purchasing Information for Instruments by Format

Instrument	Manual Entry	TELEform	HCIA-Response
GAF	not applicable *(already collected for CSI)*	not applicable *(already collected for CSI)*	not applicable *(already collected for CSI)*
*BASIS-32**	Medical Outcomes Trust Address: 8 Park Plaza, #503 Boston, MA 02116 Phone: (617) 426-4046 Fax: (617) 426-4131 E-mail: info@outcomes-trust.org Order Item # I-B-32	California Department of Mental Health 1600 9th Street Sacramento, CA 95814	HCIA-Response 950 Winter Street, Suite 450 Waltham, PA 02154 Phone: (800) 522-1440 or (781) 768-1801 Fax: (781) 768-1811
CA-QOL	California Department of Mental Health 1600 9th Street Sacramento, CA 95814	California Department of Mental Health 1600 9th Street Sacramento, CA 95814	Currently Not Available for further information call HCIA-Response
*QL-SF***	Currently Not Available for further information call HCIA-Response	Currently Not Available for further information call HCIA-Response	HCIA-Response 950 Winter Street, Suite 3450 Waltham, PA 02451 Phone: (800) 522-1440 or Deborah Rearick at (781) 522-4630 Fax: (781) 768-1811 E-mail: drear@hcia.com
MHSIP Consumer Survey	California Department of Mental Health 1600 9th Street Sacramento, CA 95814	California Department of Mental Health 1600 9th Street Sacramento, CA 95814	HCIA-Response (See Information Above)

* DMH has purchased a *BASIS-32* site license for each county from Medical Outcomes Trust. The packet includes a master copy of the instrument, royalty-free permission to reproduce and use, and a user's manual and implementation guide.

** This instrument is copyrighted and may not be duplicated without permission

County Implementation

Definition of Implementation

Each county is required to fully implement the Adult Performance Outcome System no later than July 1, 1999. Implementation of the system is defined as:

(a) Clinicians are assuring the completion of the required performance outcome instruments: the *GAF*, *BASIS-32*, one of the two quality of life instruments (*CA-QOL or QL-SF*), and the *MHSIP* Consumer Survey. For each adult client receiving services for at least 60 days, the assessment instruments are to be administered at intake, annually, and at discharge and the satisfaction instrument is to be administered annually and at discharge;

(b) Clinicians are adequately trained so that they are able to understand and use the reports and data generated from the instruments to aid in treatment planning and service provision;

(c) Counties have an established methodology for using data from the performance outcome instruments for aiding in program evaluation and quality improvement;

(d) Counties are providing scored reports generated from the instruments to clinicians (and clients when appropriate) within two weeks of completion; and

(e) Counties have operationally established a system that will allow the county to provide specified reports and client level data in electronic format to DMH no later than June 30, 1999.

Completion of Instruments

TABLE 2-3: Who Completes Each Instrument and Average Completion Time

Instrument	Completed by	Average Completion Time
GAF	Clinician	5 minutes
BASIS-32	Client	20 minutes*
CA-QOL or QL-SF	Client	20 minutes*
MHSIP Consumer Survey	Client	10 minutes*

* This completion time assumes that the client is able to read and operate at a functional level that allows them to complete the forms without assistance. If assistance is required, the average time for administration could be as high as an hour for each instrument.

TABLE 2-4: Schedule for Administering the Instruments

Schedule	Instruments to Administer	When to Administer
Intake	Assessment Instruments (i.e., *GAF*, *BASIS-32*, and one of the quality of life instruments)	Within 60 days
Periodic	Assessment Instruments *and* Client Satisfaction Instrument (*MHSIP* Consumer Survey)	Annually
Discharge	Assessment Instruments and Client Satisfaction Instrument	Upon Discharge

The schedule for completing the assessment instruments is: (1) within 60 days of the client's involvement with county mental health (sometimes referred to as "intake" for the target population), (2) annually (i.e., annual case review), and (3) upon discharge. The client satisfaction instrument should be administered annually and upon discharge.

Target Population

The target population is defined as seriously mentally ill adults (California's Welfare and Institutions Code, Section 5600.3 (b) defines "serious mental disorder"), ages 18 through 59, receiving services for 60 days or longer (those traditionally admitted to coordinated care). With the elimination of the requirements for the completion of Coordinated Care Plans under the implementation of managed care, another mechanism may be established for identifying long-term or target population clients. However, at this time, the target population is defined as adults receiving services for 60 days or longer. The instruments should be administered as soon as it is determined the client is within the target population.

Administration of Instruments to Teens

After their 18th birthday, a client should be administered the adult instruments at the time of their next regular administration of the outcome measures. This policy is being advocated because it is important that instruments be used for the group defined by the author (i.e., the group for which the instruments were developed, normed, and validated.) For example, the *CBCL* used in the Children and Youth Performance Outcome System was designed for ages 4-18, and the *YSR* was designed for ages 11-18. Administering these instruments to clients over 18 years of age may still provide some clinically useful data, but would not be appropriate for additional levels of analysis.

First Administration of Instruments

The instruments should be administered as soon as it is determined the client is within the seriously mentally ill target population. If the client will be receiving services for more than 60 days, the instruments must be administered within 60 days from "intake". Identification of the target population is an issue that will be re-examined in the future. At this time, it is acknowledged that this method of administration lacks the level of desired sensitivity regarding the initial treatment of services.

Administration to Medication Only Clients

At this time, performance outcome instruments are not required to be administered to clients receiving only medication services. Although this group of adults is admitted to county services initially as members of the target population, the administrative complexities of outpatient consolidation make it very difficult for county staff to implement while also having to deal with managed care and foster care reform. DMH, CMHPC, and CMHDA will reexamine this population to assess whether they should be included in future performance outcome measurement requirements.

Reporting Performance Outcome Data

The data that will be generated from the Adult Performance Outcome System will serve several useful purposes which include:

- Assisting clinicians with treatment planning and service provision,
- Effecting quality improvement in local mental health programs,
- Providing performance outcome data to the State and Legislature, and
- Allowing the comparison of California's public mental health programs with those of other states.

As part of its oversight process, DMH will review each county's policies and procedures to ensure that a process exists whereby performance outcome data are used to provide feedback to quality improvement staff and that methods are developed to effect program improvement based on these data.

In order to fulfill its statutory oversight responsibilities, the DMH will require that each county mental health program submit a set of client-level data in the format specified in the DMH Adult Performance Outcome Data Dictionary (a copy will be provided to all counties and can also be obtained by calling the Research and Performance Outcome Development Unit at (916) 654-0471. The method of entry and management of performance outcome data is at the discretion of each local program. However, the transmission of the data to the State will require that it be in established formats. Although specific time frames have not been established, it is likely that during the first full year of implementation, the data should be forwarded to DMH on a quarterly basis and thereafter it is to be provided on a semi-annual basis. Additionally, on an annual

basis, each county mental health program will submit statistical reports containing average and standard deviation scores from each performance outcome instrument including scales and subscales by:

- Age,
- Ethnicity,
- Gender, and
- Diagnosis.

The DMH, in its oversight role, will review these data in conjunction with data contained in the Client Services Information (CSI) data system. Counties will be asked for assistance in the interpretation of results relating to their own program performance. Reports will be generated comparing each county's mental health program performance to itself over time.

Frequently Asked Questions

- Why were these specific instruments selected?

  These instruments was selected because (1) as a set they measure all the required CMHPC domains, (2) they were the most efficient measurement of the CMHPC domains (minimum number), (3) they all have acceptable psychometric characteristics, and (4) each of the four instruments is either widely used nationally or based on a nationally recognized instrument and can provide data for comparison with other states and entities.

- How can the forms be purchased and who pays for them?

  The *GAF*, *CA-QOL*, and *MHSIP* Consumer Survey are in the public domain. Counties already provide *GAF* scores to the DMH CSI data system and will continue to do so. All counties should obtain a master of the *MHSIP* Consumer Survey from DMH and reproduce sufficient forms for all applicable adults, or require that their privately contracted providers purchase them directly. Counties choosing to use the *CA-QOL* as their quality of life instrument, should also obtain a master from DMH and reproduce sufficient forms for all applicable adults, or require that their privately contracted providers purchase them directly.

  The *BASIS-32* is not in the public domain. However, DMH has purchased a *BASIS-32* site license for each county. The packet includes a master copy of the instrument, royalty-free permission to reproduce and use, the manual and implementation guide, as well as other useful publications and information. Reproduction costs are the responsibility of the county.

  The *QL-SF* is not in the public domain. Counties choosing to use this quality of life instrument should contact HCIA/Response for purchasing information and for a copy of the scoring manual (See Table 2-2).

- Is the time associated with administering the instruments billable?

  The administration and scoring of the performance outcome instruments may be billed by treatment providers as assessment or as part of the quality improvement process.

- What should be done if a client and/or their caregiver refuses to fill out the instruments?

  Clinicians and other mental health staff should encourage clients to complete the forms. However, if all attempts of explanation, encouragement, and assistance fail, then include an explanation (such as "client refused to complete") in the file for auditing purposes. In all cases, however, the *GAF* score can still be provided by the clinician.

- In what languages are the instruments available?

TABLE 2-5: Languages Available for Adult Instruments

Instrument	Non-English Languages Available
GAF	Clinician provides this rating - instructions are available in all languages into which the DSM-IV has been translated
BASIS-32	English, Cambodian, Chinese, Korean, Spanish, Tagalog, Vietnamese
QL-SF	English only
CA-QOL	English only (*several non-English language translations are currently under development.*)
MHSIP Consumer Survey	English, Spanish (*several non-English language translations are currently under development.*)

Note: not all languages are available in all technology formats.

- How will client confidentiality be ensured?

  Steps are being taken to design systems that will ensure client confidentiality. Each client will be assigned a unique county identification code for the county to transmit the data files to the State without revealing the identify of the client. Secure data transmissions methods will be implemented. No analyses will be generated that report individual client data at the state level.

- Are these forms "culturally competent" and appropriate for use with California's diverse population?

  Unfortunately, there are no simple solutions to identifying or developing standardized assessment instruments that meet the modern conception of cultural competence. While it is possible to translate instruments into a given client's language, and even though it is possible through statistical techniques to identify what a given cultural group's scores mean in relation to other groups, it is difficult to conceptualize a single instrument that is appropriate for the interpersonal and cognitive styles of a wide variety of cultures. The DMH is working with counties to address the simpler questions first (i.e., appropriate language translations) and is committed to working with the CMHPC and CMHDA to identify ways to make the overall system truly culturally competent.

- Is there technical assistance available regarding data management/electronic transfer technologies?

  The Research and Performance Outcomes Development Unit at DMH is committed to providing county MIS staff with as much technical assistance as possible. The following assistance has been provided to date: 1) an adult data system (similar to the children's performance outcome data system) has been developed that counties will be able to use to manage their adult performance outcome data; 2) staff have worked to identify and disseminate information on the strengths and weaknesses of systems that various counties are using to manage their performance outcome data; and 3) an adult performance outcome data dictionary has been developed and disseminated to all counties identifying the specific format and files names of all data counties are required to provide relating to adult performance outcomes. For more information on this, contact Karen Purvis at (916) 653-4941.

Also, for more information about the Adult Performance Outcome System, check out the DMH web page at:

http://www.dmh.cahwnet.gov/rpod/adlt_instruments.htm

CHAPTER 3
PSYCHOMETRICS

General Information

The term "psychometrics" refers to the practice and technology of applying statistically-based techniques toward the measurement and understanding of psychological "events". These events could include attitudes, personality traits, aptitudes and abilities, and underlying factors relating to psychological functioning. In a clinical setting, which by design is generally centered on a specific individual, some feel that using statistically based assessment tools is not appropriate. Rather, these individuals feel that it is the clinician's professional judgment which grows out of the establishment of a relationship of mutual trust that is most important.

No reasonable psychometrician would claim that statistical data are more important than the relationship that exists between service provider and client. However, psychometric data can, if used appropriately, provide a very valuable piece of the puzzle that helps the clinician to develop a more complete picture of the client. Specifically, **psychometric data provide three essential components to the diagnosis, treatment planning, and service provision process**:

1. *Well-Defined Areas of Measurement*

   Scores that are derived from appropriately designed, psychometrically-based assessment instruments are generally based on well-defined areas of measurement so that something meaningful can be said about a person based on his or her score on that instrument.

2. *Reliability*

   There is evidence that the diagnostic process, when based on clinician judgment alone, is not particularly reliable. In other words, if several clinicians evaluate the same client using the same information, their diagnoses will likely differ to some degree. To the extent that specific diagnoses are more amenable to specific treatment modalities, arriving at an appropriate diagnosis is critical to providing the best service to clients. With psychometrically-based data, it is possible to state, in a quantifiable way, how much confidence may be placed in scores that describe the client. This is not to say that those scores are necessarily a complete picture of the client. But when psychometric data are used in conjunction with a clinician's clinical judgment, greater confidence may be placed in the overall treatment planning process.

3. *Validity*

The third and final essential component that psychometric data bring to the diagnosis, treatment planning, and service provision process is a quantifiable level of validity. Because of the intimate and person-centered nature of the clinician-client relationship, a wide variety of factors enter into the judgments made by the clinician about the client. For example, the nature of the clinician's training will guide diagnostic procedures and will likely lead to a focus on client behaviors that were emphasized in his or her training; the clinician's own recent and overall professional experience will affect how he or she approaches the client; because the clinician is human, it is likely that his or her own emotional state and personal beliefs will affect judgments made about the client; and finally, the administrative environment in which the clinician works will likely place constraints on how the clinician-client relationship develops.

Because of the way that psychometric-based assessment instruments are developed, it is possible--within limits--to be sure that the instrument is mainly measuring what it is supposed to measure. This is referred to as "instrument validity." Stated in other terms, validity refers to the extent to which an instrument is measuring what it is supposed to measure and that the clinician can make appropriate judgments based on the instrument score(s).

Some Basic Concepts in Psychometrics

Reliability

Broadly defined, *reliability simply refers to the confidence that you can have in a person's score*. In some cases, you want to be able to have confidence that the individual would have the same score over time. This is because you have reason to believe that what is being measured should not change over time. For example, if a person passes a driving test in January it is hoped that the same individual would pass the test one year later. At other times, it may not be appropriate to expect that scores would remain consistent over time. For example, it is hoped that if a client receives treatment for depression, the score that the client would receive on a measure of depression should decrease over time (i.e., the measure would show sensitivity to change). Psychometricians and other measurement specialists have developed various methods of establishing reliability to meet these varying needs. Some of these are listed below:

Test-Retest Reliability

In test-retest reliability methodologies, an assessment instrument is administered at time 1 and then again at some later date(s). To the extent that the scores that the client receives are the same on both administrations, the two sets of scores will be positively correlated (show a direct statistical relationship). The correlation coefficient between these two administrations then becomes an estimate of the ability of the assessment instrument to reliably assess the client over time.

Problems with this approach: The main problem with the test-retest approach to establishing validity is that a wide variety of intervening variables can come into play between the first and subsequent administrations of the instrument. From a psychological standpoint, if a person completed a measure of

depression at time one and them experienced some major life event before the second administration of the measure, the estimate of the instrument's reliability would appear low. Or, it is possible that having completed the instrument previously, the clinician's or client's responses may be affected at the second administration if he or she remembers the previous responses. If, on the other hand, it is hypothesized that whatever the assessment instrument is measuring really should not change over time, then the test-retest approach is a powerful method of establishing this fact.

Parallel Forms Reliability

Another way of establishing reliability is to develop two forms of the same instrument. In theory, if the two forms are measuring the same thing (e.g., depression), then the scores on the two forms should be highly and significantly correlated. To the extent that they are in fact correlated, the correlation coefficient is roughly a measure of parallel forms reliability.

Problems with this approach: There are several problems with this method of establishing reliability. First, it can be expensive to develop two parallel forms. The second and perhaps greater problem is that there is always a certain amount of "criterion contamination" or variance that is unrelated to what is intended to be measured in an instrument score. This is compounded in that if there is a certain amount of unsystematic variance in each assessment instrument, then the sum of that variance across the two forms will reduce the reliability between the forms.

Split-Half Reliability

This method of establishing reliability is similar to the parallel forms method--but with one important difference. To use the split-half method, an assessment instrument is administered to a group of individuals. Next the instrument is essentially randomly divided into to equal portions. These two portions are then evaluated to examine how strongly they are correlated. Assuming that the instrument is measuring a common trait, ability, or psychological dimension, each half of the randomly divided instrument should be a measure of the same thing. Therefore, scores on each half should be highly correlated.

Problems with this approach: There are two main problems with this approach. First, when you divide the assessment instrument in half, you effectively reduce the number of items from which the total score is calculated by half. Thus, you may by nature have a score on each half that is of lower reliability and therefore any correlation between the two halves could be reduced. Therefore, the overall estimate of reliability could appear inappropriately low. The second problem is that even though the assessment instrument was randomly divided, there is no guarantee that the two halves are actually equivalent. To the extent that they are not, the estimate of overall reliability will be lower.

Internal Consistency

The internal consistency approach to establishing reliability essentially evaluates the inter-item correlations within the instrument. Ultimately, an estimate of reliability is generated that is equivalent to the average of all possible split-half divisions that could have been made for that instrument.

TABLE 3-1: Summary of Reliability Methodologies

Method	Strengths	Weaknesses
Test-Retest Reliability	• Correlates scores from two separate administrations of an instrument. • Correlation coefficient estimates instrument's ability to reliably assess client over time.	• A wide variety of intervening variables between the first and subsequent administrations of the instrument could alter the results.
Parallel Forms Reliability	• Correlates scores of two forms of an instrument designed to measure the same thing. • Correlation coefficient estimates instrument's ability to measure the target domain.	• It can be expensive to develop two parallel forms. • There is always a certain amount of variance unrelated to what is intended to be measured in an instrument score that would reduce the reliability between the forms.
Split-Half Reliability	• Correlates scores for two equal, randomly divided portions of an instrument. • Correlation coefficient estimates instrument's ability to measure the target domain.	• Since only 50% of the items are used per score, the overall estimate of reliability could appear inappropriately low. • To the extent that the two halves are not equivalent, the estimate of overall reliability will be lower.
Internal Consistency	• Evaluates the inter-item correlations within the instrument. • An estimate of reliability is generated equivalent to the average of all possible split-half divisions.	

Validity

Some people misuse the term "validity" when they refer to assessment instruments. It is inappropriate to say that an assessment instrument is valid. Rather, it is the inferences or decisions that are made on the basis of an instrument's scores that are either valid or invalid. In order to be able to make valid inferences about a client based on his or her score on an instrument, the instrument must be measuring what it was intended to measure. This point cannot be emphasized enough.

When a client completes an instrument that is designed to evaluate his or her psychological functioning, if the instrument uses terms that, while common in a European cultural setting, may not be familiar in an Asian setting, then the inferences based on the instrument scores may not be appropriate for Asians. Threats to validity do not have to be nearly so extreme or obvious to make interpretation of scores invalid for making assessments. Therefore, it is important for users of test information to understand methods of test validation, the strengths and weaknesses of each, and what types of inferences are more appropriate for the method of validation that was used. Several validation methods are discussed briefly below.

Content Validity

When one says that an instrument is content valid, it indicates that the individual items that make up the instrument are reflective of the specific domain that they are intended to measure. For example, in an instrument designed to measure quality of life, if that instrument contains items such as indicators of living situation, independence, self-sufficiency, etc. (assuming these have been documented by a group of individuals as measuring quality of life), then the instrument may arguably be called "content valid."

Criterion-Related Validity

There are basically two methods of employing criterion-related validation strategies: predictive and concurrent.

In *predictive* criterion-related validation strategies, the goal is to develop an instrument that is able to predict an individual's later score, performance, or outcome based on some initial score. Examples of such predictive instruments include the General Aptitude Test Battery (GATB), Armed Services Vocational Aptitude Battery (ASVAB), Scholastic Aptitude Test (SAT), and Graduate Record Examination (GRE).

In *concurrent* criterion-related validation strategies, the goal is to effectively discriminate between individuals of groups on some current trait. For example, the Minnesota Multiphasic Personality Inventory (MMPI) was developed using a method called criterion keying to develop an instrument that was extremely powerful at identifying whether or not a person was currently experiencing psychoses.

The criterion-related validation approach can be extremely powerful. However, it suffers from a variety of conceptual and/or logistical problems. Using a criterion-related validation strategy:

- It is difficult to develop parallel forms.
- Instruments tend to have low internal consistency.
- To maximize predictive power, items should have minimal correlations with each other but maximum correlations with the external criterion. This makes it methodologically difficult to identify test items.
- Instruments tend to have low face validity.

Construct Validity

Construct validation approaches use factor analysis to identify items that appear to be highly correlated with one another. To the extent that items are, in fact, correlated they are assumed to be measuring something in common. Exactly what those items are measuring is difficult to say. What test developers do is review the content of the items and try to identify commonalties in the subject matter that they cover. For example, if a group of inter-correlated items addresses such things as sleeplessness, lack of energy, frequent crying, fear of being alone, etc., a test developer may decide that these items are measuring the construct of depression.

What is a construct? It is important to keep in mind that a construct does not exist. Rather, it is a theoretical creation to explain something that is observed. Returning to our example of a depression construct, depression is not a thing that exists. Rather, it is simply a name that we have given to a group of traits or a level of psychological functioning.

Face Validity

Face validity simply refers to the extent to which an assessment instrument "appears" to be related to what it purports to measure. For example, a written driving test is face valid because all of the questions that are asked are related to laws and situations with which a driver may be faced. Therefore, even if we don't like driving tests, most of use feel that they are at least somewhat related to driving.

On the other hand, someone may find that math ability is related to driving ability. If this occurred, it might be possible to administer a math test and, based on the scores a test taker received, either approve or deny a drivers license. In this case, a math test could be valid for use in predicting driving behavior (criterion validity), but it would not be face valid because it would "appear" unrelated to the task of driving.

Face validity is important in most assessment settings because people inherently like to make sense out of what they are doing. When clinicians, clients, family members, or anyone else are asked to fill out an assessment instrument, they will feel better about doing so and will likely provide more accurate data if they feel that the information they provide makes sense and can see how it can be useful.

TABLE 3-2: Summary of Validation Methodologies

Method	Strengths	Weaknesses
Content Validity	• Provides an indication of how the individual items that make up the instrument are reflective of the specific domain that they are intended to measure.	• Assumes that the area being measured is clearly understood. • To the extent that what is being measured is conceptual or multi-dimensional, effective content-oriented items may be difficult to develop.
Criterion-Related Validity	• *Predictive strategies* provide an indication of how well the instrument is able to predict a later score, performance, or outcome based on some initial score. • *Concurrent strategies* provide an indication of how the instrument effectively discriminates between individuals or groups on some current trait.	• It is difficult to develop parallel forms using this approach. • Instruments tend to have low internal consistency. • To maximize predictive power, items should have minimal correlations with each other but maximum correlations with the external criterion making it methodologically difficult to identify test items. • Instruments tend to have low face validity.
Construct Validity	• Utilizes factor analysis to identify items that appear to be highly correlated to one another in order to develop assessment instruments that measure a common construct.	• Exactly what a group of inter-correlated items is measuring may be difficult to ascertain.
Face Validity	• Provides an indication of how the assessment instrument "appears" to be related to what it purports to measure	• Not really an indicator of validity. Rather, it is based on the assumption that data will be more valid when respondents see the relationship between the instrument and what it is supposed to measure.

Other Relevant Statistical Indicators

Differential Functioning

Differential functioning is a measure that indicates whether groups perform differently on the same item or scale. Pilot results were evaluated on whether there were statistically significant differences between groups (ethnic, gender, age, diagnosis) based on overall results as well as results within diagnosis (schizophrenic/psychotic disorders, mood disorders, and anxiety/other non-psychotic diagnoses).

Sensitivity to Change

Sensitivity to change means that any measure with acceptable levels of validity and reliability should, within its domain, be able to measure cross-sectional differences between clients/sites/providers as appropriate as well as longitudinal change (i.e., change over time) within these units of analysis.

Conclusion

Psychometric data are intended to provide an additional tool for clinicians and other service providers to use as they plan and conduct their treatment. These data are not intended to supplant or replace clinical judgment. The above issues have been discussed to help those who use data generated from the Adult Performance Outcome System evaluate and make more effective and appropriate use of their client's assessment data.

It is important to understand which method was used to validate each of the clinical assessment instruments so that you can know what kinds of judgments may be made about the scores. Knowing that an instrument is reliable and how the reliability was established can help the clinician have confidence in the scores as well as know what kinds of changes are reasonable to expect.

Finally, the remainder of this training document goes into additional detail on each of the assessment instruments. Each instrument's validity, reliability, administration and scoring procedures, interpretation, and use will be discussed. The above information is intended to help you make sense of this.

Sources of Further Information

Adult Outcome Measurement Standards Committee. (January 1997 Draft). *Methodological Standards for Outcome Measures*. Center for Mental Health Services, 5600 Fishers Lane, 15C-04, Rockville, MD 20857.

Anastasi, A. (1982). *Psychological Testing (5th. Ed.)*. New York: MacMillan.

Crocker, L. & Algina, J. (1986). *Introduction to Classical and Modern Test Theory*. Orlando, FL.: Harcourt Brace Jovanovich College Publishers.

Ghiselli, E. E., Campbell, J. P., & Zedeck, S. (1981). *Measurement Theory for the Behavioral Sciences*. San Francisco: W. H. Freeman and Company.

Holland, P. & Wainer, H. (1993). *Differential Item Functioning*. Hillsdale, NJ.: Lawrence Erlbaum Associates.

Nunnally, J. (1978). *Psychometric Theory (2nd. Ed.)*. San Francisco: McGraw-Hill.

SECTION 4
GLOBAL ASSESSMENT OF FUNCTIONING SCALE

General Information

Global Assessment of Functioning *(GAF)* Scale

The Global Assessment of Functioning (*GAF*) Scale is a rating scale used by clinicians to indicate a client's general level of functioning. A single scale value incorporates role performance, symptomatology, and behavioral functioning. The *GAF* is widely used in clinical practice as well as in many research studies. Counties already provide a *GAF* score to the Department of Mental Health (DMH) Client and Service Information (CSI) data system.

Psychometrics

Note: Refer to Section 3 for details about psychometric techniques.

Reliability. The literature (Andrews, G., Peters, L., & Teesson, M. (1994); Jones, S.H., Thornicroft G., Coffey M., & Dunn, G. (1995) describes the *GAF* as having relatively satisfactory reliability. Inter-rater reliability of the *GAF* and the *GAF*'s predecessor (the GAS) ranged from .62 to .82. The recent Adult Performance Outcome Pilot methodology did not allow for independent verification of inter-rater reliability. *Pilot participants reported that raters needed continual training on using the GAF in order to ensure consistency. It would be advisable for counties to institute some regular clinician training on assigning GAF scores* . Since the *GAF* is a single global score, an internal consistency reliability coefficient would not be appropriate.

Validity. The literature described the validity of the *GAF* and *GAS* as adequate (Andrews, et al, 1994; Jones, et al, 1995). The *GAF* is widely used as a measure of overall functioning which indicates it apparently has face validity to users.

Differential Functioning. The adult performance outcome pilot analyzed *GAF* results to determine whether there were statistically significant differences between groups (i.e., ethnic, gender, age, diagnosis) based on overall results as well as results within diagnosis (schizophrenic/psychotic disorders, mood disorders, and anxiety/other non-psychotic diagnoses). The evaluation found no statistically significant differences for any of these groups.

Sensitivity to Change. The adult performance outcome pilot found that *GAF* mean scores improved from administration 1 to administration 2; however, these were not statistically significant changes. This held true when data were combined into one data file or when data were stratified into diagnostic categories.

Scoring

The *GAF* score is Axis V of the DSM-IV. *GAF* scale values range from 1 - 100, which represent the hypothetically lowest functioning person to the hypothetically highest functioning. Scale value 0 indicates that the clinician had inadequate information with which to rate the client. The rating scale is divided into 10 equal intervals and a general behavioral description is provided for each decile. Note: the predecessor to the *GAF* (the Global Assessment of Functioning (*GAS*)) eliminated the highest level, 91-100; however, in DSM-IV the 91-100 decile was reinstated. Although no specific scoring manual is available, directions for using the scale and interpreting the scores are included in DSM-IV, Axis V.

Although two *GAF* scores can be collected (Current *GAF* and Highest *GAF* in the last 12 months), only Current *GAF* will be reported to DMH in order to maintain consistency with the Client Service and Information (CSI) system requirements.

Administration Procedures

The *GAF* is a public domain instrument; permission for use is assumed as part of the multiaxial evaluation system in the DSM-IV classification.

Who Should Be Administered the GAF?

The *GAF* is to be administered to all target population clients (see page 2-4 for a description of the target population) within 60 days of first receiving service, annually and at discharge.

Who Should Administer the GAF?

The *GAF* score is provided by the clinician. Regular clinician training is required to maintain inter-rater reliability of scoring (consistency).

Frequently Asked Questions

- I already send in a *GAF* score to the DMH CSI data system. What will I do differently under the Adult Performance Outcome System?

  Under Adult Performance Outcome implementation, counties will continue to send in the same *GAF* score, following the same procedures as they do currently.

Sources of Further Information

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders, 4th ed.*. Washington DC, 20005.

Andrews, G., Peters, L., & Teesson, M. (1994). *The measurement of consumer outcome in mental health: A report to the National Mental Health Information Strategy Committee*. Sydney, Australia, Clinical Research Unit for Anxiety Disorders.

Jones, S.H., Thornicroft G., Coffey M., & Dunn, G. (1995) A brief mental health outcome scale: reliability and validity of the Global Assessment of Functioning. *British Journal of Psychiatry*. 166: 654-659.

Spitzer, R.L., Gibbon, M., Williams, J.B., & Endicott, J.A. (1994). Global Assessment of Functioning (GAF) Scale. In L.I. Sederer & B. Dickey (Eds.), *Outcomes Assessment in Clinical Practice* (pp. 76-78) Baltimore, MD: Williams & Wilkins.

Global Assessment of Functioning (*GAF*) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health – illness. Do not include impairment in functioning due to physical (or environmental) limitations. Use intermediate codes when appropriate, e.g., 43, 68, 72.

100 – 91	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
90 – 81	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
80 – 71	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).
70 – 61	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational , or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
60 – 51	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers.
50 – 41	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job)
40 – 31	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30 – 21	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
20 – 11	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
10 – 1	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
0	Inadequate information.

American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (4th Ed.). Washington, D.C.: American Psychiatric Association.

CHAPTER 5
BEHAVIOR AND SYMPTOM IDENTIFICATION SCALE

General Information

The Behavior and Symptom Identification Scale (*BASIS-32*) is a 32-item inventory measuring behavioral functioning and symptomatology from the client's perspective. Although originally established as a structured interview, the *BASIS-32* can also be completed as a self-administered questionnaire. The instrument can be used with adults experiencing a wide variety of symptoms and diagnoses.

Each item asks for the degree of difficulty the client has experienced in a variety of areas in the past week. Possible ratings range from a low of 0 (indicating no difficulty) to a high of 4 (indicating extreme difficulty). Results can be scored into five subscales (i.e., relation to self and others, depression/anxiety, daily living skills, impulsive/addictive behavior, and psychosis) and an overall average.

Development

The *BASIS-32* was developed by Sue Eisen, Ph.D., of McLean Hospital in Massachusetts, using psychiatric inpatients' reports of symptoms and problems. These open-ended reports were cluster-analyzed to arrive at 32 symptom and behavior items. After an initial administration of the instrument, results of a factor analysis were used to derive the five subscales.

Psychometrics

Note: Refer to Section 3 for details on psychometric techniques.

Reliability. The literature provides solid evidence of the reliability of the *BASIS-32* (Andrews & Teesson, 1994; Eisen, 1995; Eisen, 1996; Eisen, Dill, & Grob, 1994; Eisen, Wilcox, Schaefer, Culhane, & Leff, 1997; Russo, Roy-Byrne, Jaffe, Ries, Dagadakis, Dwyer-O'Connor, & Reeder, 1997). Test-retest reliabilities ranged from .65 to .81 for the five subscales. Table 5-1 below shows the range of alpha coefficients reported in the literature as well as those reported by the adult performance outcome pilot.

TABLE 5-1: BASIS-32 Reliability Coefficients

Subscales	*Literature*	*Adult Pilot*
1. Relation to self and others	.76 - .89	.90
2. Depression/anxiety	.74 - .87	.88
3. Daily living skills	.80 - .88	.89
4. Impulsive/addictive behavior	.65 - .71	.78
5. Psychosis	.63 - .66	.73
Overall (Items 1 - 32)	.89 - .95	.96

Validity. The literature provided evidence for content, concurrent, discriminant, and construct validity of the *BASIS-32* (Andrews & Teesson, 1994; Eisen, 1995; Eisen, 1996; Eisen, et al., 1994; Eisen, et al., 1997; Russo, et al., 1997). Concurrent and discriminant validity analyses indicated that *BASIS-32* ratings successfully discriminated persons with different diagnoses, employment status and re-hospitalization status. The literature also reported construct validity by correlating *BASIS-32* subscale scores with corresponding scales of other highly regarded instruments and other indicators. Resulting correlations were in the hypothesized direction. The adult performance outcome pilot also reported correlations (not statistically significant) between certain *BASIS-32* subscales and other appropriate instruments in the expected direction to confirm to some extent the construct validity of the instrument.

Sensitivity to Change. The literature has also reported that the five subscales are sensitive to change (intake to followup/discharge) as a result of treatment (Eisen et al., 1997; Russo et al., 1997). One study found statistically significant changes in each subscale ($p<.001$) as well as the overall score after hospitalization. The depression/anxiety scale was most sensitive to change, followed by daily living, relations with self and others, impulsive/addictive, and psychosis. The adult performance outcome pilot found that the *BASIS-32* was the most sensitive to change of the instruments piloted.

Differential functioning. The adult performance outcome pilot analyzed the *BASIS-32* regarding group differences and found the following:

Diagnoses combined. When all diagnoses were combined into one data base, a statistically significant difference on Subscale 2 (depression/anxiety) was found for diagnosis. Scores for group 2 (mood disorders) were significantly higher (worse) than scores for group 1 (schizophrenic/psychotic disorders).

Within diagnosis. When data were stratified by diagnosis, there were no statistically significant differences for the population subgroups of age, ethnicity, or gender.

Scoring

The *BASIS-32* is scored into five subscales and an overall average. The items comprising each subscale are listed in Table 5-2 below:

Table 5-2: Subscale Items

Subscales		Item Numbers
1.	Relation to self and others	7, 8, 10, 11, 12, 14, and 15
2.	Depression/anxiety	6, 9, 17, 18, 19, and 20
3.	Daily living skills	1, (2, 3, 4)*, 5, 13, 16, 21, and 32
4.	Impulsive/addictive behavior	25, 26, 28, 29, 30, and 31
5.	Psychosis	22, 23, 24, and 27

* These three items are used to create one "role functioning" rating by taking the highest of the three ratings.

The author recommends that the *BASIS-32* be scored only if at least 27 of the 32 items are completed. If six or more items are missing, the assessment should be considered "missing data".

Because of its brevity and simplicity, little training is required in the use of this scale. The *BASIS-32* instruction manual provides general guidelines for administration, item clarifications and elaborations, sample protocols and appropriate variations to the protocols, as well as ethical considerations regarding the rights of clients. The instruction manual was included in the site license and packet of material that DMH purchased for each county and sent to their Directors Office/Adult Program Coordinator.

Clinical Utility

The *BASIS-32* provides a structured, valid, and reliable way for collecting client data in a standardized format, which may assist clinicians in obtaining information that could be missed in an unstructured clinical interview process. Information from the *BASIS-32* was not designed to be used for clinical decision-making and cannot replace a complete clinical evaluation (Eisen, et al., 1997). Results should be used along with and compared to other sources of information in order to obtain a more complete picture of how the client is functioning.

The instrument and profile data may be used to:

- assist in validating the clinicians own judgment
- assist the clinician in tailoring interventions to the client's specific needs
- provide structure to the goal setting process by identifying specific areas to target for improvement
- provide a structured method to monitor progress in specific areas over time

How to Read the Profile/Report

A computer-scored profile is generated which shows the initial, previous, and current score for each subscale as well as listing items on which quite a bit or extreme difficulty was reported (see example near the end of this section on page 5-12).

Administration Procedures

Who Should be Administered the BASIS-32?

The *BASIS-32* is to be administered to all target population clients (see page 2-4 for a description of the target population) within 60 days of first receiving service, annually and at discharge.

Who Should Administer the BASIS-32?

Although the *BASIS-32* is intended to be self-administered, it can be administered by an interviewer if the respondent requires assistance or if there are language barriers. However, care should be taken not to interpret the client's responses or to affect the responses in any way.

Frequently asked questions

- About how long does it take for a client to complete the *BASIS-32*?

  Completion times can vary considerably depending on the client's level of functioning. The author estimates 15 minutes to complete. Actual results from the adult performance outcome pilot were that it takes on average 20 minutes, but the range of reported times was from about 5 minutes to 1 hour.

Sources of Further Information

Andrews, G., Peters, L., & Teesson, M. (1994). *The measurement of consumer outcome in mental health: A report to the National Mental Health Information Strategy Committee*. Sydney, Australia, Clinical Research Unit for Anxiety Disorders.

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Ordering Information for the *BASIS-32*

Costs

The *BASIS-32* is *not* in the public domain. DMH has purchased a *BASIS-32* site license for each county from Medical Outcomes Trust. The packet includes a master copy of the instrument, royalty-free permission to reproduce and use, the manual and implementation guide, as well as other useful publications and information.

Other county costs will vary depending on the technology used.

Manual Entry. For counties using manual entry, the site license and packet is all you need to simply reproduce the necessary number of copies.

TELE*form*. For counties using the TELE*form* technology, the State Department of Mental Health will provide any county who requests it, a copy of the TELE*form* form definition files that will allow fax-based data entry for the *BASIS-32*.

Phone: (916) 654-0471
Fax: (916) 653-5500
kpurvis@dmhhq.state.ca.us

HCIA-Response. For counties using HCIA-Response technology contact:

HCIA-Response
950 Winter Street, Suite 3450
Waltham, MA 02451
Phone: (800) 522-1440 or (781) 522-4630
FAX: (781) 768-1811
http://www.hcia.com

http://www.outcomes-trust.org/catalog/b32.htm

MEDICAL OUTCOMES TRUST

BASIS-32

Instrument packets include the questionnaire, scoring documentation, publication reprints, bibliography, *SourcePages*, and permission letter. When ordering an instrument packet, please complete the Instrument Registration Form.

BASIS-32

This is a 32-item self-administered (or structured interview) questionnaire developed to assess outcome of mental health treatment for populations undergoing inpatient psychiatric hospital care for a wide range of disorders (can also be used in outpatient populations). The five domains measured by the BASIS-32 are: psychosis; daily living/role functioning skills; relation to self/others; impulsive/addictive behavior; and depression.

Instrument Packet Includes:

- Master Copy of the Form Including Royalty Free Permission to Use and Reproduce
- 72 Page BASIS-32 Manual and Interpretation Guide
- Reprint of Publications Describing BASIS-32's Development and Measurement Properties
- Technical Notes Article: "Instruments: BASIS-32 " from the May, 1997 issue of *The Bulletin*
- Depression Outcomes Resource Packet from the January, 1997 issue of *The Monitor*
- ***SourcePages*** Health Outcomes Field Resource Guide

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BASIS-32 Scoring Sheet

Name: _____ ID#: _____ Date: _____

Relation to Self/ Others		Daily Living/ Role Functioning		Depression/ Anxiety		Impulsive/ Addictive		Psychosis		BASIS-32 Average	
ITEM	SCORE	ITEM	SCORE	ITEM	SCORE	ITEM	SCORE	ITEM	SCORE		
7		1		6		25		22			
8		* ROLE		9		26		23			
10		5		17		28		24			
11		13		18		29		27		Total Average includes responses from all 32 items. DO NOT use 'Role' in this average. Please include items 2,3 & 4.	
12		16		19		30					
14		21		20		31					
15		32									
Total		Total		Total		Total		Total		Sum Total	
# of Items		# of Items		# of Items		# of Items		# of Items		Item Total	
Average:		Average:		Average:		Average:		Average:		Total Average:	

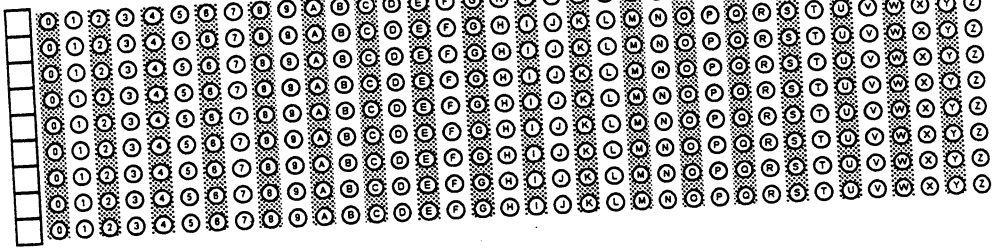
Note: **Number of Items** = Number of completed items.
Average = Column Total/ Number of Items
Total Average (BASIS-32 Average) = Sum total of all totals (include items **2,3,4**) / Total number of completed items

* **ROLE** = The highest rated item of 2, 3, 4. Do not include the scores of the two other items.

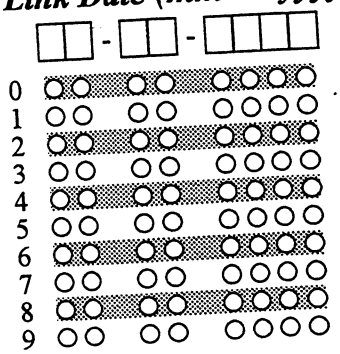
Behavior & Symptom Identification Scale - BASIS-32

Client ID Number

0 1 2 3 4 5 6 7 8 9 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

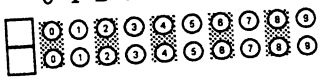


Link Date (mm-dd-yyyy)



County

0 1 2 3 4 5 6 7 8 9



Instructions: Below is a list of problems and areas of life functioning in which some people experience difficulties. FILL IN THE BUBBLE that best describes THE DEGREE OF DIFFICULTY YOU HAVE BEEN EXPERIENCING IN EACH AREA DURING THE PAST WEEK. Please respond to each item. Do not leave any blank. If there is an area that you consider to be inapplicable, indicate that it is NO DIFFICULTY.

To what extent are you experiencing difficulty in the area of:	No difficulty 0	A little 1	Moderate 2	Quite a bit 3	Extreme 4
1. Managing Day-to-Day Life. (For example, getting places on time, handling money, making everyday decisions)	○	○	○	○	○
2. Household Responsibilities. (For example, shopping, cooking, laundry, keeping room clean, other chores)	○	○	○	○	○
3. Work. (For example, completing tasks, performance level, finding/keeping a job)	○	○	○	○	○
4. School. (For example, academic performance, completing assignments, attendance)	○	○	○	○	○
5. Leisure time or recreational activities.	○	○	○	○	○
6. Adjusting to major life stresses. (For example, separation, divorce, moving, new job, new school, a death).	○	○	○	○	○
7. Relationships with family members.	○	○	○	○	○
8. Getting along with people outside of the family.	○	○	○	○	○
9. Isolation or feelings of loneliness.	○	○	○	○	○
10. Being able to feel close to others.	○	○	○	○	○
11. Being realistic about yourself or others.	○	○	○	○	○
12. Recognizing and expressing emotions appropriately.	○	○	○	○	○

do not make any marks below this line

20435

Form Linking Number

BASIS 32 (continued)

What extent are you experiencing difficulty in the area of:	No difficulty 0	A little 1	Moderate 2	Quite a bit 3	Extreme 4
13. Developing independence, autonomy.	○	○	○	○	○
14. Goals or direction in life.	○	○	○	○	○
15. Lack of self-confidence, feeling bad about yourself.	○	○	○	○	○
16. Apathy, lack of interest in things.	○	○	○	○	○
17. Depression, hopelessness.	○	○	○	○	○
18. Suicidal feelings or behavior.	○	○	○	○	○
19. Physical symptoms. (For example, headaches, aches and pains, sleep disturbance, stomach aches, dizziness)	○	○	○	○	○
20. Fear, anxiety or panic.	○	○	○	○	○
21. Confusion, concentration, memory.	○	○	○	○	○
22. Disturbing or unreal thoughts or beliefs.	○	○	○	○	○
23. Hearing voices, seeing things.	○	○	○	○	○
24. Manic, bizarre behavior.	○	○	○	○	○
25. Mood swings, unstable	○	○	○	○	○
26. Uncontrollable, compulsive behavior. (e.g., eating disorder, hand-washing, hurting yourself.)	○	○	○	○	○
27. Sexual activity or preoccupation.	○	○	○	○	○
28. Drinking alcoholic beverages.	○	○	○	○	○
29. Taking illegal drugs, misusing drugs.	○	○	○	○	○
30. Controlling temper, outbursts or anger, violence.	○	○	○	○	○
31. Impulsive, illegal or reckless behavior.	○	○	○	○	○
32. Feeling satisfaction with your life.	○	○	○	○	○

do not make any marks below this line

20435

Form Linking Number

Instruction Manual for the McLean BASIS-32©

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BACKGROUND

The Behavior and Symptom Identification Scale (BASIS-32) authored by Eisen, Grob and Dill, was developed to meet the need for a brief but comprehensive mental health status measure that would be useful in assessing outcome of psychiatric care from the patient or client's perspective. Developed on a psychiatric inpatient hospital population, it is a 32-item measure permitting assessment of patient or client self-reported difficulty in symptoms and functioning that can be administered at appropriate points in the treatment process (typically at intake, termination and a follow-up point). BASIS-32 asks for the degree of difficulty the respondent has been experiencing **DURING THE PAST WEEK.** The 32 items assess five major areas of difficulty and/or distress: relation to self/others, daily living/role functioning skills, depression/anxiety, impulsive/addictive behavior (including substance abuse) and psychosis.

BASIS-32 is **not** diagnosis-specific. It was designed to cut across diagnosis, acknowledging the wide range of symptoms and problems that occur across the diagnostic spectrum.

Information regarding the development, item derivation, reliability, validity and use of BASIS-32 in outcome studies is provided in the published papers identified in the Reference List at the end of this manual.

BASIS-32 was designed for outcome assessment purposes. Although there may be clinical uses for BASIS-32, **it is not meant to be a measure of clinical impairment and should not replace a thorough clinical evaluation.** Clinical perspectives, as well as those of family members also serve a valuable role in outcome research, as do other measures such as mortality, days hospitalized, costs and service utilization. Multiple measures of outcome add to the understanding we can gain from any outcome study.

BASIS-32 can be administered as a structured interview or as a self-report questionnaire. Although early work with BASIS-32 utilized the interview method, the great majority of recent outcome assessment efforts by behavioral health facilities have used BASIS-32 as a self-report

questionnaire. The interview mode of administration is generally used to supplement self-administration when patients/clients have difficulty completing the questionnaire themselves due to their clinical status or reading capability.

The impact of mode of administration (self-report vs. structured interview) is reported in a published article by Eisen (1995), noted on the Reference List and included in the BASIS-32 information packet. We encourage facilities to implement methods that are most feasible for them; however, the impact of these methods should be explored so that we can understand their effects on patients' responses.

Originally developed on psychiatric inpatients (Eisen, Dill and Grob, 1994), BASIS-32 is now widely used among outpatients and partial hospital patients as well. Published work with BASIS-32 is included in the Reference List at the end of this Manual. In addition, results of a recently completed outpatient study funded in part by the Human Services Research Institute, Cambridge, MA, are presented in a technical report that is included in the BASIS-32 information packet.

BASIS-32: GENERAL GUIDELINES FOR ADMINISTRATION

In the interest of standardizing BASIS-32 data collection procedures, the following guidelines apply, regardless of procedural variations.

1) Data collection should take place in a safe, comfortable and private location.

2) A clipboard and pencil should be readily available for patients or interviewers to record BASIS-32 responses.

3) Patients initially unable or unwilling to participate in the BASIS-32 data collection process should be approached again at a later time. However, an outside limit following intake should be established to standardize the time frame for baseline assessment (e.g., within 48 hours post-intake).

The data collection procedure should always include the following components:

1) personal introduction

2) explanation of the purpose. (Explanation will vary depending on the specific purposes decided by your facility.)

3) instructions for completing BASIS-32

4) assurance that it is not a test and that there are no right or wrong answers.

Staff should familiarize themselves with the BASIS-32 items. For some items, a few examples are provided on the BASIS-32 form itself. Further clarifications and elaborations of each item are noted below and should be referred to should patients have a question about a particular item.

BASIS-32: ITEM CLARIFICATIONS AND ELABORATIONS

1. **Managing day-to-day life**: deciding what to wear, what to eat, using public transportation, self-care including dressing, bathing, etc.

2. **Household responsibilities**: home management, child or elder care (if not done as paid employment), laundry, making bed, organizing clothing and personal possessions.

3. **Work**: paid employment; if unemployed, efforts to find or keep a job, preparing resumes, handling interviews, managing rehab services, career groups or job training programs. Not applicable to those not needing or wanting to work.

4. **School**: high school, vocational or technical training, college or graduate school. Recreational classes (e.g., piano lessons, self-improvement, should be included in #5 (leisure time, recreational activities).

5. **Leisure time**: difficulty structuring free time or finding things to do, boredom. Leisure time activities include hobbies, social clubs, reading, jogging, sports, fitness, etc. Also includes recreational classes; e.g., piano lessons, self-improvement, arts, etc.

6. **Adjusting to major life stresses**: medical illness, job loss, financial or housing difficulties, victim of abuse, violence, or other crime, etc. Does not include the current hospitalization. If person has experienced no major stresses, item is not applicable and should be rated "0." Adjustment to stressors should be considered during the past week. The stressors do not have to have occurred in the past week.

7. **Relationships with family members**: relatives or long-term significant others. If relationships vary with different family members, patients should give their best estimate of family relationships overall.

8. **Getting along with people outside the family**: roommates, friends, neighbors, supervisors, co-workers, teachers, boyfriend, girlfriend.

9. **Isolation, loneliness**: subjective feelings of isolation or loneliness may be independent of actual degree of contact with others.

10. **Being able to feel close to others**: feeling close (trusting, in harmony with, affectionate) to people you especially care about.

11. **Being realistic about yourself or others**: having realistic expectations; e.g., not too high or too low regarding your own behavior or that of others.

12. **Recognizing and expressing emotions appropriately**: showing appropriate affect; recognizing, acknowledging affects such as sadness, anger, affection, etc.

13. **Developing independence, autonomy**: feeling that you can take care of most things (financial, emotional, social) without being uncomfortably dependent on other people; feeling that you are in control of decisions about your life. Age, occupation and other factors may affect autonomy. This question asks about the degree to which lack of independence is problematic for the respondent.

14. **Goals or direction in life**: knowing what you want to be doing in your life; working towards a goal.

15. **Lack of self-confidence, feeling bad about yourself**: feeling that you are not a good, likable or worthwhile person; feeling stupid or incapable of accomplishing anything.

16. **Apathy, lack of interest in things**: not caring about anything, not feeling like you want to do things that you usually enjoy.

17. **Depression, hopelessness**: feeling depressed, sad, hopeless about the future, lack of pleasure in life.

18. **Suicidal feelings or behavior**: thinking about, planning, gesturing or attempting suicide by any means.

19. **Physical symptoms**: difficulty should be rated regardless of etiology (e.g., medication side effects).

20. **Fear, anxiety, panic:** nervousness, tension, jitters, agitation, fear of open spaces, heights, darkness, etc.

21. **Confusion, concentration, memory:** difficulty understanding things, thinking clearly, remembering, maintaining focus on a task.

22. **Disturbing or unreal thoughts or beliefs:** paranoid ideation (feeling as if you are being watched, poisoned, or that others can read your mind); delusions, e.g., that your body is rotting, that you can fly, that a TV personality is speaking to you personally, etc.

23. **Hearing voices, seeing things:** auditory or visual hallucinations; hearing messages or commands from a voice in one's head; seeing things that no one else can see.

24. **Manic, bizarre behavior:** racing thoughts, decreased need for sleep, increased talking, spending money, exaggerated sense of well-being; inappropriate behavior including undressing in public, speaking incoherently to strangers; behavior which others would generally consider very unusual or inappropriate.

25. **Mood swings, unstable moods:** feeling happy one minute, sad the next; frequent emotional ups and downs, often unrelated to what is going on in your life at the time.

26. **Uncontrollable, compulsive behavior:** any behavior that one feels compelled to frequently repeat including eating disordered behavior, checking, washing, gambling).

27. **Sexual activity or preoccupation:** any sexual issue experienced as problematic (e.g., impotence, sexual addiction, fetishes, sexual identity confusion, etc.)

28. **Drinking alcoholic beverages:** including difficulty dealing with urges, efforts to find alcohol.

29. **Taking illegal drugs, misusing drugs:** any illegal substance of abuse (cocaine, heroin, crack, marijuana, etc.); misuse or overuse of prescription drugs (sedatives, stimulants, diet pills, anti-anxiety agents, etc.).

30. **Controlling temper, outbursts of anger, violence:** screaming, throwing things, kicking, hitting, etc.

31. **Impulsive, illegal, or reckless behavior:** includes dangerous or illegal behavior, e.g., reckless driving, vandalism, assault, fraud, selling drugs, forging checks, etc.

32. **Feeling satisfaction with your life:** happy with what you are doing, general sense of well-being.

SAMPLE PROTOCOL FOR SELF-ADMINISTRATION (BASIS-32 scan card)

"Hello. My name is _____. I'm a nurse/doctor, mental health worker/social worker/ etc. here. Name of Program wants to provide you with the best possible care. In order for us to know how this treatment has made a difference to you, we want **you** to be involved in evaluating the care that you receive.

One of the ways we do that is by talking to patients soon after admission to get your perspective on how you are feeling and on areas of daily living in which people sometimes experience difficulty. I have a questionnaire here that lists a number of symptoms, problems and areas of life functioning. I'd like you to fill this out, indicating how much difficulty you have been experiencing in each area during the **PAST WEEK**. Please answer every question by filling in the oval with the pencil. It will take about 10 minutes. Almost all the areas apply to everyone, but there may be one or two that do not apply to you. If a question does not apply, indicate that it is "no difficulty."

This is not a test. There are no right or wrong answers. We just want to know how you are feeling in each of these areas. In a month from now (or whenever the follow-up assessment is planned), we will contact you again and ask you to complete this form again. Your responses to questions about your symptoms and any difficulties you may be having in your daily activities will help us learn about the ways in which we have been helpful to you. Do you have any questions about this?"

Give patient clipboard with BASIS-32 and #2 pencil. After getting the completed BASIS-32 from the patient, check to make sure all items on both sides of the scan card are complete and that the ovals are completely filled in. If items have not been answered, ask the patient if he or she can complete them. If more than 6 items are missing, we consider the entire questionnaire as "missing data." Thank the patient for completing the form.

PROCEDURAL VARIATIONS IN THE PROTOCOL

Appropriate variations can be made in the protocol based on the purposes and procedures for BASIS-32 data collection decided by your facility. Possible variations include:

1) data collection by a staff member (not self-administered). In this case, rather than asking the patient to fill out the form, the patient should be told, "I would like to read to you each of the areas and you can tell me how much difficulty you have been experiencing in each one during the past week. Patients should be given an index card with the 5-point rating scale (0...no

difficulty, 1...a little difficulty, 2...moderate difficulty, 3... quite a bit of difficulty and 4...extreme difficulty).

2) data collection as part of a research project. In this case, patients should be fully informed about the purposes of the research project, the procedures involved, and the risks and benefits. Written informed consent should be obtained and all guidelines regarding research with human subjects should be followed.

3) data collection that is separate from the clinical treatment process. If BASIS-32 is obtained by program evaluators who are separate from the clinical care process and ratings are to be kept confidential from clinical staff, patients should be so informed.

BASIS-32: COMMON QUESTIONS PATIENTS MAY ASK

Q. I felt worse at the beginning of the week, but better now. How should I respond?
A. Try to average how you have felt during the past 7 days including today.

Q. I can't decide between a "3" and "4" rating.
A. Suggest that the patient think about what rating comes a little closer to how they feel. If they still can't decide, suggest that they skip the item for now and come back to it at the end.

Q. I have no difficulty with some of the examples given for the item (e.g., getting places on time, but I have a lot of difficulty managing money.
A. Suggest that patients think of how much difficulty they are having in the category as a whole. The examples are not meant to include everything within each item. They are meant only to illustrate the concept.

Q. I can't do this. Will you do it for me?
A. I can't do this for you because I can't say how much difficulty you are feeling. Only you can tell me that. We want to know what you think.

Two additional questions that may arise are noted below. The answers to these questions must be decided by each facility.

Do I have to do this?
What will this be used for?

ETHICAL CONSIDERATIONS

The rights of patients or clients should be respected at all times. This includes the right to refuse to respond to the BASIS-32 assessment. Also of paramount importance is respect for patient confidentiality, especially when contacting patients or clients in their homes or other community settings to obtain follow-up assessments. The fact that someone has received psychiatric treatment at your facility or anywhere else, is confidential information. We recommend that written informed consent be obtained to contact any patient or client outside of your treatment facility, either by mail or telephone. The fact that someone has received psychiatric treatment should not be revealed to anyone answering the telephone, unless it has been ascertained that the person already knows about the treatment. Outcome assessors also have a clinical responsibility to protect patients from harm to self or others. Facilities need to design and implement clinically responsible policies that deal appropriately with patient reports of suicidality, or other threats to their own safety or to the safety of others.

BASIS-32: SCORING

BASIS-32 is scored into five subscales and an overall average. Just as each item is rated on a 5-point scale (from 0 for least difficulty to 4 for greatest difficulty), subscale and overall mean scores also range from 0 to 4. The lowest possible score is 0 (if every item is rated "no difficulty). The highest possible score is 4 (if every item is rated "extreme difficulty"). The items comprising each subscale are as follows:

Relation to self/others:	Items 7,8,10,11,12,14 and 15.
Depression/anxiety:	Items 6,9,17,18,19 and 20.
Daily living/role functioning:	Items 1,(2,3,4*),5,13,16,21 and 32.
Impulsive/addictive behavior	Items 25,26,28,29,30 and 31.
Psychosis	Items 22,23,24 and 27.
BASIS-32 Average	Items 1 though 32.

Four of the five subscale scores and the BASIS-32 average are computed by averaging the ratings for component items using the number of non-missing items as the denominator. The four subscale scores computed this way are: Relation to self/others, Depression/anxiety, Impulsive/addictive behavior and Psychosis.

For example, if the respondent answers all items in the Relation to self/others subscale, the subscale score is the sum of the ratings for items 7,8,10,11,12,14 and 15 divided by 7. If one item is omitted, the subscale score is the sum of the ratings for the items answered, divided by 6.

The same process is followed for the three other subscales noted above, using the items comprising each subscale. The only exception to this scoring process is for the Daily living/role functioning subscale. In this case, items 2,3, and 4 are used to create one "role functioning" rating by taking the **highest** of the three ratings (indicating greatest difficulty). This role functioning item is then averaged in with the other six items comprising the Daily living/role functioning subscale. The role functioning item can be created if a rating is available for at least one of the three items (2,3, or 4).

A scoring sheet is appended to facilitate manual scoring of the BASIS-32.

MISSING DATA

Missing data are **not** included in the calculation of the BASIS-32 subscale or overall mean scores. **If more than five items have been omitted, the entire instrument should be considered "missing data" and should be discarded.**

Following is an example of a computer scoring program in SPSS-PC, which can be adapted to other statistics packages. The program computes scores for each of the subscales and the overall average based on the number of non-missing items. We recommend that BASIS-32 be scored only if at least 27 of the 32 items are completed. If six or more items are missing, the assessment should be considered "missing data."

SPSS-PC PROGRAM FOR SCORING BASIS-32

```
missing values  BASIS1 to BASIS32 (9).

*  Compute BASIS subscale means for available items (omitting missing values).

count num0=BASIS7 BASIS8 BASIS10 BASIS11 BASIS12 BASIS14 BASIS15 (0).
count num1=BASIS7 BASIS8 BASIS10 BASIS11 BASIS12 BASIS14 BASIS15 (1).
count num2=BASIS7 BASIS8 BASIS10 BASIS11 BASIS12 BASIS14 BASIS15 (2).
count num3=BASIS7 BASIS8 BASIS10 BASIS11 BASIS12 BASIS14 BASIS15 (3).
count num4=BASIS7 BASIS8 BASIS10 BASIS11 BASIS12 BASIS14 BASIS15 (4).

compute selfoth=(num1+(num2*2)+(num3*3)+(num4*4))/(num0+num1+num2+num3+num4).

count num0=BASIS6 BASIS9 BASIS17 BASIS18 BASIS19 BASIS20 (0).
count num1=BASIS6 BASIS9 BASIS17 BASIS18 BASIS19 BASIS20 (1).
count num2=BASIS6 BASIS9 BASIS17 BASIS18 BASIS19 BASIS20 (2).

count num3=BASIS6 BASIS9 BASIS17 BASIS18 BASIS19 BASIS20 (3).
count num4=BASIS6 BASIS9 BASIS17 BASIS18 BASIS19 BASIS20 (4).

compute depress=(num1+(num2*2)+(num3*3)+(num4*4))/(num0+num1+num2+num3+num4).

if ((BASIS3 le BASIS2) and BASIS4 le BASIS2))role=BASIS2.
```

```
if ((BASIS2 le BASIS3) and BASIS4 le BASIS3))role=BASIS3.
if ((BASIS2 le BASIS4) and BASIS3 le BASIS4))role=BASIS4.

count num0=BASIS1 role BASIS5 BASIS13 BASIS16 BASIS21 BASIS32 (0).
count num1=BASIS1 role BASIS5 BASIS13 BASIS16 BASIS21 BASIS32 (1).
count num2=BASIS1 role BASIS5 BASIS13 BASIS16 BASIS21 BASIS32 (2).
count num3=BASIS1 role BASIS5 BASIS13 BASIS16 BASIS21 BASIS32 (3).
count num4=BASIS1 role BASIS5 BASIS13 BASIS16 BASIS21 BASIS32 (4).

compute livskill=(num1+(num2*2)+(num3*3)+(num4*4))/(num0+num1+num2+num3+num4).

count num0=BASIS25 BASIS26 BASIS28 BASIS29 BASIS30 BASIS31 (0).
count num1=BASIS25 BASIS26 BASIS28 BASIS29 BASIS30 BASIS31 (1).
count num2=BASIS25 BASIS26 BASIS28 BASIS29 BASIS30 BASIS31 (2).
count num3=BASIS25 BASIS26 BASIS28 BASIS29 BASIS30 BASIS31 (3).
count num4=BASIS25 BASIS26 BASIS28 BASIS29 BASIS30 BASIS31 (4).

compute impulse=(num1+(num2*2)+(num3*3)+(num4*4))/(num0+num1+num2+num3+num4).

count num0=BASIS22 BASIS23 BASIS24 BASIS27 (0).
count num1=BASIS22 BASIS23 BASIS24 BASIS27 (1).
count num2=BASIS22 BASIS23 BASIS24 BASIS27 (2).
count num3=BASIS22 BASIS23 BASIS24 BASIS27 (3).
count num4=BASIS22 BASIS23 BASIS24 BASIS27 (4).

compute psychot=(num1+(num2*2)+(num3*3)+(num4*4))/(num0+num1+num2+num3+num4).

*   compute overall average BASIS score.

count num0=BASIS1 to BASIS32 (0).
count num1=BASIS1 to BASIS32 (1).
count num2=BASIS1 to BASIS32 (2).
count num3=BASIS1 to BASIS32 (3).
count num4=BASIS1 to BASIS32 (4).

compute BASmean=(num1+(num2*2)+(num3*3)+(num4*4))/(num0+num1+num2+num3+num4).

var labels  selfoth 'relation to self and others subscale'
            depress 'depression-anxiety subscale'
            livskill 'daily living skills subscale'
            impulse 'impulsive-addictive behavior subscale'
            psychot 'psychosis subscale'.
```

CHAPTER 6
QUALITY OF LIFE INSTRUMENTS

General Information

Counties are to *choose one* of the following quality of life instruments:

- Lehman's Quality of Life - Short Form (*QL-SF;* formerly known as the *TL-30S*)
- California Quality of Life (*CA-QOL*)

Brief Descriptions

Lehman's Quality of Life - Short Form (QL-SF) is a 38-item quality of life instrument developed statistically from Lehman's longer Quality of Life - Brief Interview (*QOL-B*). Domains measured include general living situation, daily activities and functioning, family and social relationships, finances, work and school, legal and safety issues, and health. It is intended to be self-administered by clients; however, some clients in the target population may need assistance. The *QL-SF* is not in the public domain.

California Quality of Life (CA-QOL) is a 40-item quality of life instrument, also developed using items from the *QOL-B.* It measures the same domains as the *QL-SF* when supplemented by information from the DMH CSI data system (the *CA-QOL* measures some of the domains specified by the CMHPC in a manner that relies on other external data sources and thereby reduces redundancy). The *CA-QOL* serves as an alternative to the *QL-SF*. *QL-SF* scores can be equated to those on the *CA-QOL*. It is also intended to be self-administered by clients; however, some clients in the target population may need assistance. The *CA-QOL* is a public domain instrument.

Reason Why Counties Have Choice of Two Instruments

The adult performance outcome pilot recommended that one of Lehman's quality of life instruments be selected for the adult performance outcome program. Further discussions regarding a quality of life instrument resulted in the recommendation of the *QL-SF*, Lehman's shorter, self-administered quality of life instrument. However, in order to respond to questions which arose about the availability and cost of the *QL-SF* and to provide flexibility to counties, the State Department of Mental Health (DMH), the California Mental Health Planning Council (CMHPC), and the California Mental Health Director's Association (CMHDA) agreed to develop an alternative, self-administered quality of life instrument (the California Quality of Life or *CA-QOL*). Counties could, at their discretion, choose to use either quality of life instrument (the *QL-SF* or the *CA-QOL*).

Development

QL-SF. The *QL-SF* was developed statistically from Lehman's Quality of Life Brief Interview (*QOL-B*) using a sample of 32 clients. Little research information was available about the specific development of, or psychometric qualities of, the *QL-SF* at the time of writing this training manual. However, some additional information about the *QL-SF* was obtained during the quality of life pilot described below.

CA-QOL. Dr. Anthony Lehman, a professor at the University of Maryland and the developer of the Lehman Quality of Life Long Interview (*QOL-L*) and Quality of Life Brief Interview (*QOL-B*) as well as the *QL-SF*, gave DMH permission to select and modify items from the *QOL-L* and *QOL-B* (both public domain instruments) to develop a new quality of life instrument. A draft of the instrument (named the *CA-QOL*) was developed by representatives from DMH, CMHPC, and CMHDA. The committee was composed of the following individuals:

- *Department of Mental Health*
  Jim Higgins, Ed.D. and Karen Purvis, M.S.W.

- *County Mental Health Programs*
  Tracy Herbert, Ph.D., Sacramento County
  David Williams, Ph.D., San Mateo County

- *California Mental Health Planning Council*
  Ann Arneill-Py, Executive Officer

- *Additionally, the following individuals served as consultants*
  Sybille Guy, Ph.D., Riverside County Mental Health
  Astrid Beigel, Ph.D., Los Angeles County Mental Health
  Amando Cablas, Ph.D., Santa Clara County Mental Health

The *CA-QOL*, in combination with information from the CSI system, measures the same domains as the *QL-SF* (see Table 6-1 for a comparison of the number of objective and subjective items within each subscale).

A follow-up pilot assessed the *CA-QOL*'s psychometric properties and comparability to the *QL-SF*. Sacramento County and San Mateo County administered both quality of life instruments (*QL-SF* and *CA-QOL*) to a sample of 198 seriously mentally ill adult mental health clients in a rotated order. Statistical results are reported below.

Psychometrics

Note: Refer to Section 3 for details on psychometric techniques.

Comparability. Table 6-2 presents the statistical correlations between relevant subscales of the two instruments. Scores on both instruments generally correlate well. Two *QL-SF* objective subscales (living situation and daily activities) could not be compared with comparable *CA-QOL* subscales because these data will be obtained from the CSI data system. Also, a few subscales had to be recomputed so that they provided comparable data.

Reliability. Table 6-2 also presents overall and subscale reliability coefficients for both instruments as estimated by internal consistency statistics.

- The overall reliability of the *CA-QOL* is high (.93).

- The overall reliability of the *QL-SF* is lower (.70 based on an internal consistency measure of reliability), even when removing the "if yes" questions and #20 "how do you like the D/T scale". Reliability goes up slightly (.71) if questions 2 through 5 are removed (comparable questions are not on the *CA-QOL*). Reliability is lower for the *QL-SF* probably due to the fact that it is composed mostly of objective items of yes/no or categorical format and usually only one item per subjective subscale. The appropriate reliability strategy would be test-retest which was not possible given the design of this pilot test.

- The reliability of all *CA-QOL subjective* scales is relatively high (.84 to .93), while the reliability of the three *CA-QOL objective* scales with more than 1 item is modest (.67 to .75).

- The reliability of *QL-SF* subjective scales can only be computed for General Life Satisfaction (it is slightly lower than for same two items on *CA-QOL*). Reliability cannot be computed for any other *QL-SF* subjective subscales since the rest have only one item.

- The reliability coefficients of the same three *QL-SF* objective subscales reported for the *CA-QOL* are also modest (.73 - .76).

Validity. Both instruments were based on Lehman's *QOL-Brief* instrument which has demonstrated validity. By extrapolation, the *QL-SF* and *CA-QOL* may be inferred to be valid (cross-content linking between the *QL-SF* and the *CA-QOL* to the *QOL-B*). Additionally, both instruments measure the CMHPC domains and so are assumed to be content valid for purposes of the California Adult Performance Outcome System.

Differential functioning. An analysis of subscale scores by demographic category indicated only minor statistically significant differences. For the purposes of the pilot report, these were defined as differences in scale scores which are statistically significant at the .05 level and which account for at least 10% of the systematic variance of the differences between subgroup scale scores. Note in some cases, statistically significant differences were found between scale scores within the *QL-SF* and *CA-QOL;* but upon further analysis using moderately conservative post hoc tests to identify where these differences were occurring, no significant differences were found. It is possible that these differences were either artifacts and occurred only by chance or that the number of individuals in the particular subgroups (e.g., age category) was too small to allow for meaningful analysis of differences.

Diagnoses Combined. An analysis of scale scores by demographic category indicated only minor statistically significant differences when all diagnoses were analyzed together. Trends were similar for both instruments. When analyzed by diagnostic category, one scale met the criteria for identifying meaningful difference. For the *QL-SF*, on the scale "General Life Satisfaction," clients diagnosed with mood disorders had significantly lower scores than clients diagnosed with schizophrenia or other psychotic diagnoses. The trend was similar for the *CA-QOL*. However, differences in the *CA-QOL* did not meet the criteria for identifying meaningful statistically significant differences.

Diagnosis 1 (Schizophrenia/Psychotic Diagnoses). The only meaningful differences within diagnosis 1 were found for the *CA-QOL* for the category age on two scales: "General Life Satisfaction" and "Satisfaction with Living Situation." Post hoc tests did not pinpoint these differences as explained above; however, on both instruments the youngest and oldest groups had higher mean scores than did the intermediate age categories.

Diagnosis 2 (Mood Disorders). Meaningful differences within diagnosis 2 were only found for three objective scales. On both the *CA-QOL* and *QL-SF* differences were found for age for "Amount of Spending Money." Clients in the youngest age category reported having less money to spend on themselves than did clients in the other age categories.

There were also differences on the *QL-SF* on the scale "Adequacy of Finances." Although post hoc tests did not pinpoint these differences, the tendency (on both instruments) was for the youngest and oldest age categories to report having the least money for various items. It is possible that these differences could be an artifact of low numbers.

Additionally, there was a meaningful difference found for ethnicity on "General Health Status." Although post hoc tests did not pinpoint these differences, on both instruments Asians tended to have the highest mean scores and Caucasians the lowest mean scores. It is possible that these differences could be an artifact of low numbers.

Scoring

Instructions for the QL-SF

The *QL-SF* instruction manual can only be purchased through HCIA-Response. The *QL-SF* instruction manual provides background information, general guidelines for administration of the instrument, and scoring procedures.

Instructions for the CA-QOL

The *CA-QOL* instruction manual is available through DMH at no cost. A copy of the scoring manual is also included at the end of this section.

Table 6-1
Comparison of Items in the *QL-SF* and *CA-QOL* Subscales
(using Lehman's Categories)

Subscale Names	Objective Items		Subscale Names	Subjective Items	
	QL-SF	CA-QOL		QL-SF	CA-QOL
- - -	- - -	- - -	General Life Satisfaction	1, 19	1, 17
Type of Living Situation	2	*CSI	Satisfaction with Living Situation	3	2b 2a, 2c
Types of Productive Activities	4a1, 4b1, 4c1, 4d1, 4e1	*CSI	Satisfaction with Leisure Activities	6	3c 3b, 3d
			Satisfaction with Daily Activities	7	3a
Nbr. of Days Spent in Productive Activities	4a2, 4b2, 4c2, 4d2, 4e2	*CSI			
Main Productive Activity	5	- - -			
Frequency of Family Contacts	8a, 8b	4, 5	Satisfaction with Family Relationships	9	6b 6a
Frequency of Social Contacts	10a, 10b, 10c, 10d	7a, 7b, 7c, 7d	Satisfaction with Social Relationships	11	8d 8a,8b,8c
Amount of Spending Money	12	9	Satisfaction with Finance	14	11b 11a, 11c
Adequacy of Finances	13a, 13b, 13c, 13d, 13e	10a, 10b, 10c, 10d, 10e			
Victim of Violence	15a	12a	Satisfaction with Safety	16	14c 14a, 14b
Victim of Non-violent crime	15b	12b			
Arrested	15c	13			
General Health Status	17	15	Satisfaction with Health	18	16a 16b, 16c

* Will be obtained through the CSI data system

Table 6-2
Summary of Quality of Life Pilot Statistics Grouped in Lehman *QL-SF* Domains

Subscales	**California Quality of Life (*CA-QOL*)**			**Lehman's Quality of Life-Short Form (*QL-SF*)**			
	Number of Items	Subscale Mean	Subscale Reliability	Number of Items	Subscale Mean	Subscale Reliability	**Subscale Correlations**
Subjective							
General Life Satisfaction	2	3.88	.89	2	3.97	.86	.85
Satisfaction with Living Situation	3	4.32	.89	1	4.36	*	.71
Satisfaction with Leisure Activities	3	4.16	.87	1	3.89	*	.68
Satisfaction with Daily Activities	1	4.14	*	1	3.94	*	.73
Satisfaction with Family Relations	2	4.27	.93	1	4.27	*	.82
Satisfaction with Social Relations	4	4.23	.89	1	4.04	*	.66
Satisfaction with Finances	3	3.17	.92	1	3.24	*	.81
Satisfaction with Safety	3	4.50	.84	1	4.43	*	.69
Satisfaction with Health	3	3.89	.87	1	4.09	*	.75
Overall for Subjective	24	4.10	.95	10	4.06	.89	
Objective							
Frequency of Family Contacts	2	3.37	.67	2	2.64	.76	-.84
Frequency of Social Contacts	4	2.91	.75	4	3.31	.73	-.82
Amount of Spending Money	1	2.23	*	1	2.22	*	.76
Adequacy of Finances	5	0.68	.75	5	0.69	.73	.82
Victim of Crime	2	0.092	.67	2	0.066	.47	.60
Arrested	1	0.02	*	1	0.01	*	.40
General Health Status	1	3.24	*	1	3.28	*	.82
Overall for Objective	16	1.68	.57	16**	1.64	.57	
OVERALL	40		.93	32***		.70	

* 1 item only, ** includes only items with comparable *CA-QOL* data, *** removed "if yes" items & #20

Clinical Utility

Both instruments provide a relatively brief, structured way to assess self-reports of the quality of life for persons with severe mental illness. The instruments provide both an objective measure about a quality of life indicator as well as the client's subjective feelings of satisfaction about that indicator.

Administration Procedures

Who Should Be Administered the QL-SF or CA-QOL?

The quality of life instrument selected by the county is to be administered to all target population clients (see page 2-4 for a description of the target population) within 60 days of first receiving service, annually and at discharge.

Who Should Administer the QL-SF or CA-QOL?

Although both instruments are intended to be self-administered, each can be administered by an interviewer if the respondent requires assistance or if there are language barriers.

It is likely that some clients in the target population may require assistance. Assistance may be provided by different staff or team members, including a nurse, case manager, psychiatrist, other staff, or a peer counselor. However, when assistance is provided, it should be limited to reading the question and noting the client's response. Sometimes it may be necessary to define a term for a client. However, at no time should the person administering the form attempt to interpret or clarify the client's responses in a way that may affect the responses.

Frequently asked questions

- Which quality of life instrument should I use?

  It depends on the county; each form has advantages and disadvantages related to cost, flexibility of formatting, technology availability, etc.

- About how long does it take for a client to complete the *QL-SF* or *CA-QOL* instruments?

  The author of the *QL-SF* estimated that it would take about 10 minutes to complete. However, actual results from the adult quality of life performance outcome pilot were that it takes on average 20 minutes to complete the *QL-SF* and approximately 18 minutes to complete the *CA-QOL*. The range of reported times for both instruments was from about 5 minutes to as long as 1 hour. Approximately 75% of the pilot participants were able to complete either instrument in 20 minutes or less and approximately 90% were able to complete either instrument in 30 minutes or less.
  Completion times for both instruments can vary considerably depending on the client's level of functioning.

- Can we really expect our clients to complete these instruments unassisted?

  Most pilot participants were able to complete either instrument without assistance (approximately 60%). Approximately 23% required some assistance. Relatively few participants required total interviewer administration (approximately 15%).

Sources of Further Information

References for Dr. Lehman's longer, public domain quality of life instruments:

Lehman, A.F. (1988) A Quality of Life Interview for the chronically mentally ill. *Evaluation and Program Planning*. 11:51-62.

Lehman, A.F. (1994). Quality of Life Interview (QOLI). In L.I. Sederer & B. Dickey (Eds.), *Outcomes Assessment in Clinical Practice* (pp. 117-119) Baltimore, MD: Williams & Wilkins.

Lehman, A., Kernan, E., & Postrado, L. *Toolkit for Evaluating Quality of Life for Persons with Severe Mental Illness*. Center for Mental Health Services Research, University of Maryland School of Medicine, Department of Psychiatry, Baltimore, MD.

Lehman, A.F., Possidente, S., & Hawker, F. (1986). The quality of life of chronic patients in a State Hospital and in community residences. *Hospital and Community Psychiatry*. 37:901-907.

Lehman, A.F., Postrado, L.T., & Rachuba, L.T. (1993). Convergent validation of quality of life assessments for persons with severe mental illnesses. *Quality of Life Research*. 2:327-333.

Reference for Dr. Lehman's self-administered quality of life instrument (the QL-SF):

Lehman, A. F. (DMH received Summer 1998). Quality of Life Interview: Self-Administered Short Form (*TL-30S* Version) Manual. Center for Mental Health Services Research, Department of Psychiatry, University of Maryland at Baltimore.

Reference for the CA-QOL

Purvis, K. & Higgins, J. Pilot to Evaluate Alternative Quality of Life Assessment Instruments. Research and Performance Outcome Development Unit, California State Department of Mental Health, October 1998.

Ordering Information

Costs

The *QL-SF* is *not* in the public domain and must be purchased through a private vendor (see HCIA-Response below).

The *CA-QOL* is in the public domain and can be obtained from the Department of Mental Health, Research and Performance Outcome Development Unit. No costs are associated with acquiring it for use. It may be duplicated, formatted, and/or translated according to the county's need.

TELE*form*. For counties using the TELEform technology, the State Department of Mental Health will provide any county who requests it, a copy of the TELEform form definition files that will allow fax-based data entry for the CA-QOL.

HCIA-Response. For counties using the *QL-SF* with HCIA-Response technology, contact them at the number below for ordering information.

HCIA-Response
950 Winter Street, Suite 3450
Waltham, MA 02451
Phone: (800) 522-1440 *or*
Debbie Rearick (781) 522-4630
FAX: (781) 768-1811

http://www.hcia.com

California Quality of Life (CA-QOL)*

Client ID Number

0 1 2 3 4 5 6 7 8 9 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Link Date (mm-dd-yyyy)

0 1 2 3 4 5 6 7 8 9

County

0 1 2 3 4 5 6 7 8 9

Instructions: **Below is a set of questions about your life. Please answer each question by filling in the bubble that best describes your experience or how you feel. Please fill in only one bubble for each question.**

General Life Satisfaction

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
1. How do you feel about your life in general?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Living Situation

2.Think about your current living situation. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The living arrangements where you live?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The privacy you have there?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The prospect of staying on where you currently live for a long period of time?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Daily Activities & Functioning

3.Think about how you spend your spare time. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The way you spend your spare time?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The chance you have to enjoy pleasant or beautiful things?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The amount of fun you have?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
D. The amount of relaxation in your life?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Client ID Number (Must be entered on each page and is used to link pages)

*Adapted from the Full and Brief versions of the Lehman Quality of Life Interview.

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Family

4. In general, how often do you talk to a member of your family on the telephone?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all
- ○ no family

5. In general, how often do you get together with a member of your family?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all
- ○ no family

6. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The way you and your family act toward each other?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The way things are in general between you and your family?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Social Relations

7. About how often do you do the following?

A. Visit with someone who does not live with you?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all

B. Telephone someone who does not live with you?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all

C. Do something with another person that you planned ahead of time?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all

D. Spend time with someone you consider more than a friend, like a spouse, a boyfriend or a girlfriend?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all

8. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The things you do with other people?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The amount of time you spend with other people?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The people you see socially?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
D. The amount of friendship in your life?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

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Finances

9. On average, how much money did you have to spend on yourself in the past month, not counting money for room and meals?

○ less than $25 ○ $25 to $50 ○ $51 to $75 ○ $76 to $100 ○ more than $100

10. During the past month, did you generally have enough money to cover the following items?

	No	Yes
A. Food?	○	○
B. Clothing?	○	○
C. Housing?	○	○
D. Traveling around for things like shopping, medical appointments, or visiting friends and relatives?	○	○
E. Social activities like movies or eating in restaurants?	○	○

11. In general, how do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The amount of money you get?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. How comfortable and well-off you are financially?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The amount of money you have available to spend for fun?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Legal & Safety

12. In the past month, were you a victim of:

	No	Yes
A. Any violent crimes such as assault, rape, mugging, or robbery?	○	○
B. Any nonviolent crimes such as burglary, theft of your property or money or being cheated?	○	○

13. In the past month, have you been arrested or picked-up for any crimes?

○ *0 arrests* ○ *1 arrest* ○ *2 arrests* ○ *3 arrests* ○ *4 arrests* ○ *5 arrests* ○ *6 or more arrests*

14. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. How safe you are on the streets in your neighborhood?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. How safe you are where you live?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The protection you have against being robbed or attacked?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

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Health

15. In general, would you say your health is:

○ excellent ○ very good ○ good ○ fair ○ poor

16. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. Your health in general?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. Your physical condition?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. Your emotional well-being?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Global Rating

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
17. How do you feel about your life in general?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

18. How did you become involved with this program?

○ **I decided to come in on my own.**

○ **Someone else recommended that I come in.**

○ **I came in against my will.**

The California Quality of Life Survey (CA-QOL) is adapted from Dr. Anthony Lehman's Quality of Life Interview (Full and Brief versions) by a committee representing the State Department of Mental Health, California Mental Health Directors Association, and the California Mental Health Planning Council with the written permission of Dr. Lehman. Questions about the CA-QOL should be directed to the California Department of Mental Health, 1600 9th Street, Sacramento, CA, 95814. For more information about the Lehman Quality of Life Interview, contact: Anthony Lehman, M.D., Department of Psychiatry, University of Maryland Medical Center, 645 West Redwood Street, Baltimore, MD 21201.

Client ID Number (Must be entered on each page and is used to link pages)

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QUALITY OF LIFE QUESTIONNAIRE
(QL-SF)

MARKING INSTRUCTIONS
CORRECT MARK ● INCORRECT MARKS ✓ ⊗ ⬬

INSTRUCTIONS: This questionnaire asks about your quality of life, how you are doing and how you feel about things. Please read each question carefully and then mark your response by filling in the appropriate oval.

Several questions use the DELIGHTED-TERRIBLE Scale to help you tell how you feel about different things in your life.

Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
						
1	2	3	4	5	6	7

EXAMPLE 1: To illustrate how you use this scale, we will use the example of chocolate ice cream. If you love chocolate ice cream, you might say that you feel "Delighted" about it and fill in oval 7.

EXAMPLE 2: If you hate chocolate ice cream, you might say that you feel "Terrible" about it and fill in oval 1.

EXAMPLE 3: If you feel so-so about chocolate ice cream, you might say that you feel "Mixed" about it and fill in oval 4.

Not all questions use this scale. Some ask you to respond "yes" or "no", and others ask you to rate your answers in different ways. In all cases, just fill in the best oval for your answer.

Start with Questions A, B and C to the right, then continue with the rest of the questions.

A. How old are you?
- ○ Less than 18
- ○ 18 – 24
- ○ 25 – 34
- ○ 35 – 44
- ○ 45 – 54
- ○ 55 – 64
- ○ 65 – 74
- ○ 75 or Older

B. What is your sex?
- ○ Male
- ○ Female

C. Which of these groups best describes your family origin?
- ○ Asian/Pacific Islander
- ○ African-American
- ○ [illegible]n/Alaskan Native
- ○ [illegible]
- ○ White
- ○ Other

1. Fill in the oval on the DELIGHTED-TERRIBLE Scale that best describes **how you feel about your life in general?**

1 ☹ ☹ ☹ 😐 ☺ ☺ ☺
① ② ③ ④ ⑤ ⑥ ⑦

2. Fill in the oval that best describes where you have been living during the past month? (Fill in only one oval.)

2
- ○ In a house or apartment alone or with a spouse, friend, family or children
- ○ In a house, apartment or boarding home where a mental health professional like a counselor or case manager visits regularly
- ○ In a treatment program or boarding home where a mental health professional like a counselor or case manager is there all or almost all the time
- ○ In a hospital or nursing home
- ○ In a jail or prison
- ○ On the streets or in an emergency shelter for the homeless

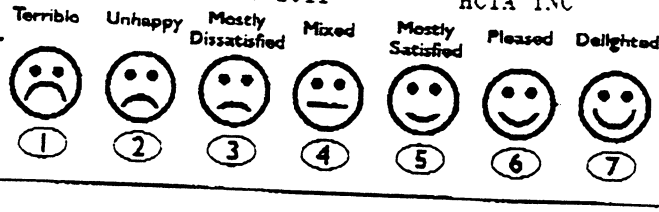
3. Fill in the oval on the DELIGHTED-TERRIBLE Scale that best describes **how you feel about the privacy you have where you live?**

3 ☹ ☹ ☹ 😐 ☺ ☺ ☺
① ② ③ ④ ⑤ ⑥ ⑦

PLEASE TURN OVER CARD FOR MORE QUESTIONS.

0 0 0 9 1 1

The DELIGHTED-TERRIBLE Scale



4. During the past month, did you do the following?

a. During the past month, did you work at a job for pay? 4 ○ Yes ○ No

If YES, about how many days did you spend on a job? 5 ○ 1-5 days ○ 6-10 days ○ 11-15 days ○ 16 days or more

b. During the past month, did you go to school? 6 ○ Yes ○ No

If YES, about how many days did you spend in school? 7 ○ 1-5 days ○ 6-10 days ○ 11-15 days ○ 16 days or more

c. During the past month, did you do volunteer work? 8 ○ Yes ○ No

If YES, about how many days did you spend as a volunteer? 9 ○ 1-5 days ○ 6-10 days ○ 11-15 days ○ 16 days or more

d. During the past month, did you keep house or take care of children? 10 ○ Yes ○ No

If YES, about how many days did you spend keeping house or taking care of children? 11 ○ 1-5 days ○ 6-10 days ○ 11-15 days ○ 16 days or more

e. During the past month, did you go to a day program? 12 ○ Yes ○ No

If YES, about how many days did you spend at the program? 13 ○ 1-5 days ○ 6-10 days ○ 11-15 days ○ 16 days or more

5. Which of these activities did you consider your main activity during the past month? (Fill in one oval only.) 14

- ○ Working at a job for pay
- ○ Going to school
- ○ Doing volunteer work
- ○ Keeping house/taking care of children
- ○ Going to a day program
- ○ None of these

6. Fill in the oval on the DELIGHTED-TERRIBLE Scale that best describes **how you feel about the amount of fun you have.** 15

7. Fill in the oval on the DELIGHTED-TERRIBLE Scale that best describes **how you feel about how you spend your time.** 16

8. Fill in the oval that best answers each of the following two questions. (Fill in only one oval for each question.)

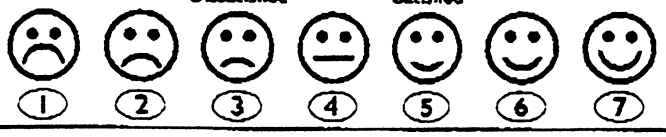
		Daily	Weekly	Monthly	Less than monthly	Not at all
a. How often do you talk to a member of your family on the telephone?	17	○	○	○	○	○
b. How often do you get together with a member of your family?	18	○	○	○	○	○

9. Fill in the oval on the DELIGHTED-TERRIBLE Scale that best describes **how you feel about the way things are in general between you and your family.** 19

PLEASE CONTINUE WITH THE NEXT QUESTIONS.

FOR OFFICE USE ONLY Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ Ⓕ

The DELIGHTED-TERRIBLE Scale



10. Fill in the oval that best answers each of the following four questions. (Fill in only one oval for each question.)

		Daily	Weekly	Monthly	Less than monthly	Not at all
a. How often do you spend time with a friend who does not live with you?	20	○	○	○	○	○
b. How often do you phone a friend who does not live with you?	21	○	○	○	○	○
c. How often do you make plans ahead of time to do something with a friend?	22	○	○	○	○	○
d. How often do you spend time with someone you consider more than a friend, like a boyfriend, girlfriend or your spouse?	23	○	○	○	○	○

11. Fill in the oval on the DELIGHTED-TERRIBLE Scale that best describes **how you feel about the amount of friendship in your life.** 24 ① ② ③ ④ ⑤ ⑥ ⑦

12. Fill in the oval next to the amount of money you had to spend on yourself during the past month, not counting money for room and board (housing and meals). (Fill in only one oval.) 25

○ Less than $20 ○ $20 to $50
○ $51 to $100 ○ More than $100

13. Answer YES or NO to each of the following questions. (Fill in only one oval for each question.)

a. In the past month, did you have enough money for food?	26	○ Yes	○ No
b. In the past month, did you have enough money for clothes?	27	○ Yes	○ No
c. In the past month, did you have enough money for housing?	28	○ Yes	○ No
d. In the past month, did you have enough money for transportation?	29	○ Yes	○ No
e. In the past month, did you have enough money for fun?	30	○ Yes	○ No

14. Fill in the oval on the DELIGHTED-TERRIBLE Scale that best describes **about how well you are financially.** 31 ① ② ③ ④ ⑤ ⑥ ⑦

15. Answer YES or NO to each of the following questions. (Fill in only one oval for each question.)

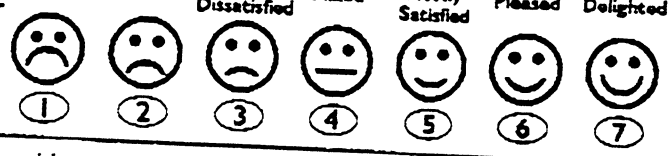
a. In the past month, were you the victim of any violent crime like assault, rape, mugging or robbery?	32	○ Yes	○ No
b. In the past month, were you the victim of any non-violent crime like a theft, burglary or being cheated?	33	○ Yes	○ No
c. In the past month, have you been arrested or picked up for any crime?	34	○ Yes	○ No

16. Fill in the oval on the DELIGHTED-TERRIBLE Scale that best describes **how you feel about the protection you have against being robbed or attacked.** 35 ① ② ③ ④ ⑤ ⑥ ⑦

PLEASE TURN OVER CARD FOR THE REST OF THE QUESTIONS.

FOR OFFICE USE ONLY Ⓐ Ⓑ Ⓒ Ⓓ Ⓔ Ⓕ

The DELIGHTED-TERRIBLE Scale



17. Overall, how would you rate your health? (Fill in only one oval.) 36

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

18. Fill in the oval on the DELIGHTED-TERRIBLE Scale that best describes **how you feel about your health in general.** 37

19. Fill in the oval on the DELIGHTED-TERRIBLE Scale that best describes **how you feel about your life in general.** 38

20. What do you think of the DELIGHTED-TERRIBLE Scale? Fill in the oval that best describes what you think. (Fill in only one oval.) 39

- ○ I liked it. It should be used.
- ○ I have mixed feelings. It doesn't matter if you use it or not.
- ○ I did not like it. It should not be used.

THIS IS THE END OF THE QUESTIONNAIRE. THANK YOU. THE REST OF THE CARD IS FOR OFFICE USE ONLY.

Episode of Care

Location/Site/Provider Code

Date Completed MM-DD-CCYY

Visit Type

- ○ Intake/Admission
- ○ Discharge
- ○ Mid-Treatment
- ○ Follow Up/Post Tx

Assistance Type

- ○ Self-Administered
- ○ Translation Assistance Needed
- ○ Other Assistance Needed

Primary DSM Code

Secondary DSM Code

GAF Score

0 0 0 9 1 1

Scoring Manual

for the

California Quality of Life (*CA-QOL*)

Prepared by the California Department of Mental Health
Research and Performance Outcome Development Section

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ACKNOWLEDGMENTS

The California Department of Mental Health would like to express its appreciation to the California Mental Health Directors Association and the California Mental Health Planning Council for their support and assistance in the development and implementation of the Adult Performance Outcome System, of which this manual is a part. Additionally, we would like to express our gratitude to the leadership, staff, and mental health consumers of Sacramento and San Mateo counties for their assistance in the development of the California Quality of Life (*CA-QOL*) Survey. We would also like to thank Dr. Anthony Lehman, Department of Psychiatry, University of Maryland, for his permission to use items from his public domain quality of life instruments in order to develop a survey instrument particularly suited to California's needs.

For more information about the *CA-QOL* contact:

California Department of Mental Health
Research and Performance Outcome Development Unit
1600 9th Street
Sacramento, California 95814

Phone (916) 654-0471

FAX (916) 653-5500

Scoring Manual
for the
California Quality of Life

I. BACKGROUND

Introduction

Under the leadership of the State Department of Mental Health (DMH), the California Mental Health Planning Council (CMHPC), and the California Mental Health Directors Association (CMHDA), a pilot project was conducted to assess instruments for use in California's Adult Performance Outcome System. The recommendation that resulted from this pilot was that the following instruments be selected for statewide implementation: the Global Assessment of Functioning (*GAF*) Scale, the Behavior and Symptom Identification Scale (*BASIS-32*), a quality of life survey instrument, and a consumer satisfaction program evaluation instrument.

Further meetings regarding a quality of life instrument resulted in the selection of the *QL-SF* (formerly called the *TL-30S*), Dr. Anthony Lehman's shorter, self-administered quality of life instrument. Additionally, in order to respond to subsequent questions about the availability and cost of the *QL-SF* and to provide greater flexibility to the counties, the DMH, CMHPC, and CMHDA agreed to develop an alternative, self-administered, public domain quality of life instrument (the California Quality of Life or *CA-QOL*). If the *CA-QOL* proved sufficiently comparable to the *QL-SF*, counties could, at their discretion, choose to use either quality of life instrument for the Adult Performance Outcome System.

Development of the *CA-QOL*

DMH obtained written permission from Dr. Lehman to select and modify items from his public domain Quality of Life Interview Instruments (*QOL-Brief* and *QOL-Long*) in order to develop a new quality of life instrument particularly suited to California's needs. A small committee of representatives from DMH, CMHPC, and CMHDA then developed a draft of the new quality of life instrument, the *CA-QOL*, extracting items from both the *QOL-Brief* and *QOL-Long*.

The *CA-QOL* consists of 40 items and measures the same domains as the *QL-SF* when supplemented with information from DMH's Client Services Information (CSI) data system. In order to minimize the data collection burden on counties, while measuring the CMHPC domains, the committee agreed to obtain as much data as possible from the CSI system.

Pilot Methodology

Two counties (Sacramento and San Mateo) volunteered to administer both quality of life instruments to a sample of seriously mentally ill adult mental health clients. The counties attempted to obtain a heterogeneous sample with particular emphasis on obtaining adequate numbers of both men and women. Information was also gathered on the client's ethnicity and age, as well as primary diagnosis within broad categories. Categories of diagnosis found to be useful in the previous pilot were: (1) schizophrenia and other psychotic disorders, (2) mood disorders, and (3) anxiety and other diagnoses. Pilot protocols were developed and distributed before the counties began administering the instruments. These protocols addressed clinician training, instrument administration issues, and data collection and reporting issues

Pilot Results

Both instruments were administered in a rotated order to a sample of 198 seriously mentally ill adult mental health clients. In general, pilot participants included adequate numbers within age categories, major ethnic groups, gender, and the two major diagnostic categories to allow for statistical analysis. There was little missing data.

Most client participants were able to complete either of the instruments without assistance (approximately 60%). Approximately 23% of the clients required some assistance and only about 15% required total interviewer administration. On average, it took clients 20 minutes to complete the *QL-SF* and 18 minutes to complete the *CA-QOL*. The range of reported times for both instruments was from about five minutes to as long as one hour. Approximately 75% of the clients were able to complete either instrument in 20 minutes or less, and approximately 90% of the clients were able to complete either instrument in 30 minutes or less. Completion times for both instruments could vary considerably depending on the client's level of functioning.

In general, average scores on corresponding scales were quite similar and correlated well. An analysis of scale scores by demographic category indicated only minor statistically significant differences.

Based on an internal consistency measure of reliability (Cronbach's alpha), the overall reliability of the *CA-QOL* was found to be high (.93), while the overall reliability of the *QL-SF* was lower (.70). The reliability of the three *CA-QOL objective* scales with more than one item was modest, as was the reliability of the same three *QL-SF* objective subscales. The reliability of all *CA-QOL subjective* scales was relatively high. The reliability of *QL-SF* subjective scales can only be computed for the two items which make up the "General Life Satisfaction" scale, and it was slightly lower than for same two items on *CA-QOL*. Internal consistency coefficients of reliability cannot be computed for any other *QL-SF* subjective scales since the other scales have only one item.

Both instruments were based on Lehman's *QOL-B and QOL-L* instruments which have demonstrated validity and reliability. By extrapolation, it is assumed that the *QL-SF* and *CA-QOL* are valid. Additionally, the instruments are assumed to be valid for purposes of the California Adult Performance Outcome System because they measure what they are supposed to measure; i.e., the CMHPC quality of life domains.

For more detailed information on statistical results, a copy of the summary report entitled "A Pilot to Evaluate Alternative Quality of Life Assessment Instruments", can be obtained by writing the California Department of Mental Health, Research and Performance Outcome Development Unit, 1600 9th Street, Sacramento, California, 95814.

Conclusions of Pilot

In many ways the instruments are similar:

- Both instruments provide a relatively brief, structured way to assess the quality of life of persons with severe mental illness.

- Both instruments are based on Lehman's public domain quality of life instruments and, as a result, item content and format are similar.

- When combined with the CSI data system, both instruments adequately measure the quality of life domains which are of interest to the CMHPC.

- The completion time required and assistance needed were similar for both instruments.

- There was little differential impact within scales of either instrument.

- Mean scores are quite similar for corresponding scales, and correlations between these scales are generally high. No meaningful differences were found between scale scores across instruments. Scores from the *QL-SF* can be statistically equated to those on the *CA-QOL* using regression techniques.

In some ways the CA-QOL has advantages for California:

- The *CA-QOL* is in the public domain. This not only eases the financial burden on counties, but makes it possible to revise the instrument's format or develop language translations to meet California's needs.

- An analysis of the psychometric properties of the *CA-QOL* indicates it compares very favorably with the *QL-SF*. It is somewhat faster to complete, and its overall and scale reliability based on internal consistency is better.

- The *CA-QOL* minimizes the data collection burden on counties, while still measuring the CMHPC domains, by obtaining as much data as possible from California's CSI data system. However, although this eliminates redundant questions, it also limits the instrument's usefulness for national comparisons because certain data elements are missing.

- Although both instruments, when combined with CSI data, measure the same CMHPC domains, the *CA-QOL* provides more complete information of the subjective, client satisfaction scales.

The purpose of the pilot was to determine whether the *CA-QOL* and *QL-SF* could be equated and to analyze the psychometric properties of the two instruments. After a review of the initial pilot results, the conclusion of this project is that the *CA-QOL* can serve as a valid alternative to the *QL-SF*. Additional data are still being gathered and will be appended when they are available.

II. GENERAL GUIDELINES

Clinical Integration

The key to the successful implementation of the adult performance outcome measurement system is effective clinical integration of the performance outcome instruments. The *CA-QOL* is one part of a set of instruments. The information provided by the set of outcome instruments can furnish valuable clinical information. However, unless clinicians understand how to interpret and integrate this information into the diagnosis, treatment planning, and service provision process, the data will not be used effectively.

The results of the adult performance outcome instruments are not intended to replace the skills used by clinicians to complete a thorough evaluation, design a treatment plan, or monitor progress. Many of the questions are similar to the questions clinicians already ask as part of their clinical assessment. However, asking these questions in a standardized format, in combination with clinical assessment skills and additional data sources, gives a more comprehensive and objective clinical profile of an individual client.

Uses

The *CA-QOL* results can provide useful information for assessment and treatment planning (e.g., assessing a client's satisfaction with quality of life, developing a baseline for satisfaction with quality of life, identifying areas of strength or weakness, and developing a treatment plan). The *CA-QOL* results can also be useful for monitoring/evaluating progress, identifying a need for additional resources, and evaluating the effectiveness of treatment.

Administration

The *CA-QOL* should be administered along with the other assessment instruments at intake (once a client has been determined to be part of target population), yearly, and at discharge. The Adult Performance Outcome Training Manual gives more specific information on administration procedures for the adult performance outcome instruments. A copy of the Adult Performance Outcome Training Manual can be obtained by writing the California Department of Mental Health, Research and Performance Outcome Development Unit, 1600 9th Street, Sacramento, California, 95814.

As indicated earlier, the *CA-QOL* was intended to be administered as a self-report, but the pilot found that assistance may be required. This assistance does not necessarily have to be provided by the clinician.

III. SCORING PROCEDURES

Scoring of the *CA-QOL* is relatively straightforward. Items can be scored individually or as part of a scale score. Computing scale scores consists primarily of calculating averages for scales with more than one item. There are two types of items: subjective items and objective items. All subjective items use the same 7-point scale. Objective items use a variety of formats. Scale scores can be computed for each type. An overall quality of life score would not be appropriate because of the varying item content and format.

The specific items comprising each of the scales are listed in Table 1 below. *Note*: scoring of the alternate quality of life instrument, the *QL-SF*, is also relatively simple. Counties selecting the *QL-SF* can obtain a scoring manual by contacting Deborah Rearick of HCIA/Response at (781) 522-4630 or writing HCIA/Response Technologies at
950 Winter Street, Waltham, MA, 02451.

Missing Data

Scale scores should not be computed if there are any missing data for that scale. Because most scales are composed of no more than two or three items, even a single non-response to the items in that scale significantly affects an aggregated score.

Subjective Scales

All of the items measuring subjective scales use the same 7-point ordinal scale. Respondents should mark only one answer for each item. Items should be coded as indicated in Table 1.

Table 1
Coding for Subjective Scales

Subjective Scales	Items	Coding for Subjective Items
General Life Satisfaction	1, 17	1 = Terrible
Satisfaction with Living Situation	2a, 2b, 2c	2 = Unhappy
Satisfaction with Leisure Activities	3b, 3c, 3d	3 = Mostly Dissatisfied
Satisfaction with Daily Activities	3a	4 = Mixed
Satisfaction with Family Relationships	6a, 6b	5 = Mostly Satisfied
Satisfaction with Social Relations	8a, 8b, 8c, 8d	6 = Pleased
Satisfaction with Finances	11a, 11b, 11c	7 = Delighted
Satisfaction with Safety	14a, 14b, 14c	
Satisfaction with Health	16a, 16b, 16c	

In order to obtain the scale score, simply compute the average of all of the items listed next to each scale. For example, for the scale "Satisfaction with Living Situation", assume that a consumer marks a score of **4** on Item 2a, a score of **5** on Item 2b, and a score of **6** on Item 2c. The average of these three scores would be the sum of 4 + 5 + 6 (which is 15) divided by 3 for an average (mean) score of 5. "Daily Activities" is the only area in which an average cannot be computed since it consists of only one item.

Objective Scales

As mentioned previously, certain objective categorical information necessary to measure CMHPC outcome domains is already being gathered by the CSI data system and was not included in the *CA-QOL*. These two areas are: Type of Living Situation and Types of Productive Activities (e.g., work, education, volunteering). The *CA-QOL* does gather subjective information about these domains. The items measuring the remaining seven objective scales come in a variety of formats and should be coded as described in Table 2. As noted previously, these items can be scored individually or combined into scale scores where appropriate (for scales with more than one item).

Note that item number 13 (number of arrests) and item number 15 (health status) are coded so that higher values are a negative outcome. On all other items, higher values indicate a positive outcome.

Table 2
Coding for Objective Scales

Objective Scales	Items	Coding for Objective Items	Scale Scores
Frequency of Family Contacts	4, 5	0 = no family 1 = not at all 2 = less than once a month 3 = at least once a month 4 = at least once a week 5 = at least once a day	Compute mean (excluding those responding 0)
Frequency of Social Contacts	7a, 7b, 7c, 7d	1 = not at all 2 = less than once a month 3 = at least once a month 4 = at least once a week 5 = at least once a day	Compute mean
Amount of Spending Money	9	1 = less than $25 2 = $25 to $50 3 = $51 to $75 4 = $76 to $100 5 = more than $100	Single score
Adequacy of Finances	10a, 10b, 10c, 10d 10e	0 = No 1 = Yes	Compute percent yes/no
Victim of Crime	12a, 12b	0 = No 1 = Yes	Compute percent yes/no
Arrested	13	0 = 0 arrests 1 = 1 arrests 2 = 2 arrests 3 = 3 arrests 4 = 4 arrests 5 = 5 arrests 6 = 6 arrests	Single score Note: for this item high scores are a negative outcome.
General Health Status	15	1 = excellent 2 = very good 3 = good 4 = fair 5 = poor	Single score Note: for this item high scores are a negative outcome.

CHAPTER 7
MENTAL HEALTH STATISTICS IMPROVEMENT PROGRAM (MHSIP) CONSUMER SURVEY

General Information

The *Mental Health Statistics Improvement Program (MHSIP) Consumer Survey* is a public domain instrument that was developed as one part of the complete MHSIP Report Card by a Task Force of the MHSIP Advisory Committee of the Center for Mental Health Services. The Task Force included mental health consumers, representatives of federal, state, and local mental health agencies; advocacy groups; researchers; and policy analysts. The MHSIP Consumer Survey asks questions relating to general satisfaction, access to services, appropriateness of treatment, and outcomes of care. The latest "short version" of the MHSIP Consumer Survey consists of 26 items. This instrument was selected for implementation in the Adult Performance Outcome Program because it:

- is acceptable to consumers (consumers reported that it was easy to understand, relevant to their concerns, and easy to complete);
- efficiently measures a variety of important domains;
- is psychometrically sound; and
- allows national comparisons (several states are currently using this version).

Development

The original 40-item *MHSIP* Consumer Survey was piloted by five states (Rhode Island, Colorado, Texas, Virginia, and New Mexico). Based on guidance from the NCQA Behavioral Measurement Advisory Panel, a shorter 21-item version of the instrument was developed. The reduced item set was obtained by using an algorithm that selected items on the basis of their unique contribution to a domain in combination with logical and exploratory factor analytic procedures. In addition to reducing the overall number of items, problem items with negative wording were revised.

A revised 26-item version is now available. Differences in the latest version include changes in wording to make it more applicable to the California setting and the addition of certain items important to consumers.

Psychometrics

Note: Refer to Section 3 for details on psychometric techniques.

The MHSIP Consumer Survey was not part of the Adult Performance Outcome Pilot because it was not widely used at the time and little evaluative information was available. However, the instrument has now been extensively piloted in other states. The MHSIP Task Force has reported that the 21-item version has psychometric features similar to the original 40-item version. In the five state study, the reliability coefficients for the domain scales ranged from .65 to .87. The 26-item version is expected to have similar results. The Department of Mental Health (DMH) will be monitoring the psychometrics of this instrument nationally and during implementation in California.

DMH has added four questions to the official 26-item version:

The first additional question asks clients how they became involved with the program and is intended to provide valuable information about whether the client came in voluntarily or involuntarily. Answer options are, (1) I decided to come in on my own, (2) Someone else recommended that I come in, and (3) I came in against my will.

The second additional question asks: "What would you like changed to improve this program?" and leaves space for written responses. This question goes beyond inquiring about the client's satisfaction with care and empowers the individual to suggest changes.

The third and fourth additional questions ask about whether the client attends a self-help group (answer options are yes, not available, and no); and, if yes, how often he or she participates (answer options are daily, weekly, monthly, occasionally). These questions will be used to gauge client commitment to participation in their program, as well as to evaluate the effectiveness of self-help.

Scoring.

The completion of this instrument is relatively straightforward. Respondents rate their level of agreement or disagreement with each of the first 26 statements on a scale with values ranging from strongly agree to strongly disagree and not applicable. The average percentage score for each domain is calculated (i.e., compute the average ratings for the items in each domain for all completed surveys, excluding scores of 0) and these scores are used to compare programs on these measures. Table 7-1 below shows the items to be scored within each domain.

TABLE 7-1: MHSIP Consumer Survey Domains

Domains	***Item Numbers***
1. Access	4, 5, 6, 7, 8, 19
2. Appropriateness	9, 10, 11, 12, 13, 14, 15, 16, 17, 18
3. Outcomes	20, 21, 22, 23, 24, 25, 26
4. Satisfaction	1, 2, 3

Scoring procedures that seem to have worked for researchers in the field have been to compute the means for each item or domain and graph changes over time. It is not appropriate to analyze overall scores. The key is to provide analyses that support the county's program evaluation efforts. The goal is to use the data for quality feedback.

Administration Procedures

The *MHSIP* Consumer Survey is to be administered to all target population clients (see page 2-4 for description a of the target population) annually and at discharge.

Note that, **unlike the Children's Performance Outcome program**, the adult satisfaction instrument (the *MHSIP*) should be distributed on the same date as the other instruments (with the exception that this instrument is not administered at intake). This is because the *MHSIP* is much more than a satisfaction questionnaire. It collects a variety of information on perceived outcomes, access to care and service appropriateness. In addition to being useful for program evaluation, this information will be linked to the other outcome instruments to measure the California Mental Health Planning Council's domains.

How Should the MHSIP Consumer Survey be Administered?

DMH, acting on the recommendations of the Performance Outcome Advisory Group (POAG), is requiring counties to collect the following information as part of the *MHSIP* survey: identification number, county code, and link date.

- The client ID number is the client's CDS/CSI case number.
- The county code is the county's CDS/CSI identification number.
- The link date is the date used to link the set of forms administered to a client at a given assessment. It is not necessarily the date the client was scheduled for instrument administration, although it can be. Whatever date is used, it should be relatively close to the scheduled administration date and must be the same as the link date used on the other instruments (see Chapter 11, page 11-14).

Before the *MHSIP* is given to the client for completion, it is critical that the correct *client identification number, county code, and link date* be entered in the appropriate fields. This information should be identical on each of the forms for a given administration. Additionally, the client should be informed that his or her responses will not be shared directly with the clinician and will only be used for program evaluation purposes.

Confidentiality

Client confidentiality must be assured as part of the process of collecting consumer satisfaction data. Therefore, it is recommended that when a client is sent or handed a satisfaction survey, a notice of confidentiality of data be included to reassure the client.

To encourage accurate responses, it is crucial that respondents to the *MHSIP Consumer Survey* be assured confidentiality of their responses so they will not have any fear of retribution. **It should never be returned directly to the clinician**. It is recommended that it be placed in a sealed envelope after completion by the respondent. Clinicians and other service providers should only receive aggregate summary data.

A county may want to provide an "Assurance of Confidentiality" letter along with the instrument when given to the respondents. The following is an example of the text of such a letter:

"This letter is to assure you as a client receiving mental health services through [*insert your agency name*] that the MHSIP Consumer Survey that you are about to fill out is confidential. Your therapist will not see this and your responses will in no way affect your right to service. Because [*insert county name*] County will use the results to improve quality of service, we are interested in your honest opinions, whether they are positive or negative. Thank you for your cooperation and help in improving our service to you."

Frequently Asked Questions

- What if a consumer wants assistance in completing this instrument?

  Some assistance in the mechanics of how to complete the form may be provided by clerical staff or a peer counselor; however, actual responses to the questions should be made only by the consumer.

- What if the client is unsure of what is meant by self-help?

  Self-help is defined as a group in which people help themselves and provide support to others. Self-help can include self-help meetings, self-help centers, learning new skills, and/or peer counseling. There is no charge to members. There is no professional counselor in attendance.

Sources of Further Information

American College of Mental Health Administration (1997). *The Santa Fe Summit on Behavioral Health: Preserving quality and value in the managed care equation, Final Report*. Pittsburgh, PA: American College of Mental Health Administration.

Center for Mental Health Services (1996). *Consumer Oriented Mental Health Report Card. The Final Report of the Mental Health Statistics Improvement Program (MHSIP) Task Force on a Consumer-Oriented Mental Health Report Card*.

Ganju, Vijay (August 1998). From Consumer Satisfaction to Consumer Perception of Care. *Behavioral Healthcare Tomorrow*, pp. 17-18.

National Association of State Mental Health Program Directors Research Institute, Inc. (May 1, 1998). *Five State Feasibility Study on State Mental Health Agency Performance Measures - Draft Executive Summary*. Developed under contract from the Survey and Reports Branch, Division of State and Community Systems Development, Center for Mental Health Services, (contract no. 280-96-0003).

Teague, Gregory B.; Ganju, Vijay; Hornik, John A.; Johnson, J. Rock; McKinney, Jacki (1997). The MHSIP mental health report card: a consumer-oriented approach to monitoring the quality of mental health plans. *Evaluation Review*. 21(3): 330-341.

Ordering Information

The MHSIP Consumer Survey is a public domain instrument. Master copies may be obtained by contacting the Department of Mental Health at:

Department of Mental Health
Research and Performance Outcome Development
1600 9th Street, Sacramento, CA 95814
Phone (916) 654-0471, FAX (916) 653-5500

HCIA-Response. For counties using the *MHSIP* with HCIA-Response technology, contact them at the number below for ordering information.

HCIA-Response
950 Winter Street, Suite 3450
Waltham, MA 02451
Phone: (800) 522-1440, FAX (781) 768-1811
http://www.hcia.com

MHSIP Consumer Survey

This survey was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services.

INSTRUCTIONS: This survey will help us to improve our mental health services for you. Your answers will be kept confidential and will only be used to evaluate and improve the services here. Please indicate your agreement or disagreement with each of the statements below. Fill in the circle that best represents your opinion.

Client ID Number

0 1 2 3 4 5 6 7 8 9 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

County

0 1 2 3 4 5 6 7 8 9

Link Date (mm-dd-yyyy)

0 1 2 3 4 5 6 7 8 9

		Strongly Agree 5	Agree 4	I am Neutral 3	Disagree 2	Strongly Disagree 1	Not Applicable 0
1.	I like the services that I received here.	○	○	○	○	○	○
2.	If I had other choices, I would still choose to get services from this agency.	○	○	○	○	○	○
3.	I would recommend this agency to a friend or family member.	○	○	○	○	○	○
4.	The location of services was convenient *(parking, public transportation, distance, etc.)*	○	○	○	○	○	○
5.	Staff were willing to help as often as I felt it was necessary.	○	○	○	○	○	○
6.	Staff returned my calls within 24 hours.	○	○	○	○	○	○
7.	Services were available at times that were good for me.	○	○	○	○	○	○
8.	I was able to get all the services I thought I needed.	○	○	○	○	○	○
9.	Staff here believed that I could grow, change, and recover.	○	○	○	○	○	○
10.	I felt safe to raise questions or complain.	○	○	○	○	○	○
11.	Staff told me what side effects to watch for.	○	○	○	○	○	○
12.	Staff respected my wishes about who is, and is not, to be given information about my treatment.	○	○	○	○	○	○

Please Continue on Page 2

Client ID Number (Must be entered on each page and is used to link pages)

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	Strongly Agree 5	Agree 4	I am Neutral 3	Disagree 2	Strongly Disagree 1	Not Applicable 0
13. Staff were sensitive to my cultural/ethnic background.	○	○	○	○	○	○
14. Staff helped me so that I could manage my life and recover.	○	○	○	○	○	○
15. I felt that I was treated with respect by the receptionist.	○	○	○	○	○	○
16. I felt comfortable asking questions about my treatment and medication.	○	○	○	○	○	○
17. Staff and I worked together to plan my treatment.	○	○	○	○	○	○
18. I, not staff, decided my treatment goals.	○	○	○	○	○	○
19. I was given written information that I could understand.	○	○	○	○	○	○

As a Direct Result of Services I Received:

20. I deal more effectively with daily problems.	○	○	○	○	○	○
21. I am better able to control my life.	○	○	○	○	○	○
22. I am better able to deal with crisis.	○	○	○	○	○	○
23. I am getting along better with my family.	○	○	○	○	○	○
24. I do better in social situations.	○	○	○	○	○	○
25. I do better in school and/or work.	○	○	○	○	○	○
26. My symptoms are not bothering me as much.	○	○	○	○	○	○

27. How did you become involved with this program?

○ I decided to come in on my own.
○ Someone else recommended I come in.
○ I came in against my will.

28. What would you like to see changed about this program? (Write comments in box below)

29. Do you currently attend self-help?

○ Yes ○ Not Available ○ No

30. If YES, how often do you participate?

○ Daily ○ Weekly ○ Monthly ○ Occasionally

Client ID Number (Must be entered on each page and is used to link pages)

20830

CHAPTER 8
CALIFORNIA'S PERFORMANCE OUTCOME DOMAINS[1] AND INDICATORS FOR ADULTS WITH SERIOUS MENTAL ILLNESSES

The California Mental Health Planning Council (CMHPC) has been assigned by the legislature the authority and responsibility for establishing performance outcome domains for adults with serious mental illnesses (SMI) in the California public mental health system and to approve the specific indicators to be used to measure these outcome domains. The performance outcome domains approved by the CMHPC for adult clients with SMI are: Living Situation, Financial Status, Productive Daily Activity, Psychological and Physical Health, Avoiding Legal Problems, and Social Support Network (Cultural Competence is listed in Attachment 1 as a process indicator).

This section lists these domains and under each provides one or more indicators approved by the CMHPC which can be used to evaluate a county's performance in that domain. An appendix at the end of this section contains copies of relevant CSI variables.

I. Outcome Domain[1]: Living Situation

Value[1]:

Adult clients with serious mental illnesses (SMI)[2] have the right to live in a satisfying environment with as much privacy and independence as possible given their mental or physical illness(es).

➡ **Desired Outcome 1:**

Adult clients with SMI are living in the most appropriate setting (i.e., privacy, independence, etc.) given their functional ability and mental and physical health.

Indicator

Evaluation of changes over time in the percentage of adult clients with SMI in various living situations by level of psychological functioning and level of physical functioning.

Possible Data Sources:

- *Living arrangement:*
  QL-SF *#2*
  CSI[3] P-09.0
- *Psychological functioning:*
  BASIS-32 Depression and Anxiety Scale, and Psychosis Scale
  CSI S-09.0 (Principal MH Diagnosis)
  S-10.0 (Secondary MH Diagnosis)
  GAF Score P-04.0

I. Outcome Domain: Living Situation (cont.)

➡ **Desired Outcome 1 (cont.)**

- *Physical functioning:*
  BASIS-32 #19

  CA-QOL #15 (rate health - 5 categories)
  #16a, #16b (satisfaction with health/physical condition)
  (mean score 5+ on D/T scale)

  QL-SF #17 (rate health - 5 categories)
  #18 (satisfaction with health *(mean score 5+ on D/T scale)*)

  CSI S-11.0 (field may be used to report additional Mental Health (MH) or Physical Health diagnoses)
  P-07.0 (Do physical health disorders affect MH? Yes/No)

Indicator
Evaluation of changes over time in the percentage of adult clients with SMI in less restrictive versus more restrictive living situations.
(Categorize CSI Living Arrangement codes by level of restrictiveness)

Possible Data Sources:
CSI P-09.0

➡ **Desired Outcome 2:**
Adult clients with SMI report acceptable levels of satisfaction with their living situation.

Indicator
Increase over time in the percentage of adult clients with SMI who report being satisfied (mean score 5+ on D/T scale) with their living situation.

Possible Data Source:
CA-QOL Satisfaction with Living Situation Subscale
This subscale includes items:
#2a (general satisfaction), #2b (privacy), #2c (permanency)

QL-SF #3 (privacy)

II. Outcome Domain: Financial Status

Value:
Adult clients with serious mental illnesses (SMI) should have sufficient income for food, clothes, housing, transportation, and fun.

➡ **Desired Outcome:**

Adult clients with SMI report having sufficient income for food, clothes, housing, transportation, and fun.

Indicator 1

Evaluation of changes over time in the amount of available income reported (after paying for housing and food).

Possible Data Sources:

*CA-QOL #*9 (income categories - reported for last month)
QL-SF #12 (income categories - reported for last month)
(recoded categories for both are $50 or under, $51 to $100, or over $100

Indicator 2

Evaluation of changes over time in the percentage of adult clients with SMI who report having sufficient income for food, clothes, housing, transportation, and fun.

Possible Data Sources:

CA-QOL #10a,b,c,d,e
QL-SF #13a,b,c,d,e
(both instruments ask "did you have enough money to cover the above categories" yes/no responses for each)

➡ **Desired Outcome:**

Adult clients with SMI report acceptable levels of satisfaction with their financial status.

Indicator

Increase over time in the percentage of adult clients with SMI who report that they are satisfied (mean score of 5+ on D/T scale) with their financial situation.

Possible Data Sources:

CA-QOL #11a (amount of money get), #11b (how comfortable financially),
#11c (amount available for fun)
QL-SF #14 (how well off financially)

III. Outcome Domain: Productive Daily Activity

Value:
Adult clients with serious mental illnesses (SMI) have the right to be involved in meaningful and satisfying activities, including educational, volunteer, and work programs.

➡ **Desired Outcome:**
Adult clients with SMI are participating in productive activities such as educational, volunteer, and work programs.

Indicator 1

Increase over time in the percentage of adult clients with SMI who report participation in productive activities (i.e., educational, volunteer, or work programs).
(this will be analyzed overall as well as broken down into the three separate categories: education, volunteer, work)

Possible Data Sources:

QL-SF	#4a (paid job), 4b (school), 4c (volunteer), 4e (day program) #5 (which one was main activity)
CSI [3]	P-03.0 (Employment status - including full-time, part-time; non-competitive job market, and not in paid work force (e.g., student, volunteer, actively looking for work)

Indicator 2

Increase over time in the percentage of adult clients with SMI who report having less difficulty with daily activities (i.e., educational, volunteer, or work programs).
(this will be analyzed overall as well as broken down into the three separate categories: education, volunteer, work)

Possible Data Sources:

BASIS-32	Daily Living Scale (which includes #3, #4, and #5) or individual items #3 (work), #4 (school), #5 (leisure)
MHSIP [4]	#25 ("I do better in school and/or work")

III. Outcome Domain: Productive Daily Activity (cont.)

Indicator 3

Increase over time in the percentage of adult clients with SMI who report acceptable levels of satisfaction (mean score of 5+ on D/T scale) with leisure activities.

Possible Data Sources:

CA-QOL Satisfaction with Leisure Activities Scale	
	#3b (pleasant things), #3c (fun), #3d (relaxation)
	#3a (satisfaction with way spend spare time),
QL-SF	#6 (satisfaction with amount of fun)
	#7 (satisfaction with how spend time)

IV. Outcome Domain: Psychological and Physical Health

Value:
The amount of psychological distress that adult clients with serious mental illnesses (SMI) experience should be minimized.

➡ **Desired Outcome:**
Adult clients with SMI are experiencing less psychological distress.

Indicator 1
Increase over time in the percentage of adult clients with SMI who report a decreased level of psychological distress.

Possible Data Sources:

BASIS-32	Psychosis Scale, Depression/Anxiety Scale, Impulsive/Addictive Scale
CA-QOL	#1, #17 (general life satisfaction) #16c (emotional well-being)
QL-SF	#1, #19 (general life satisfaction) (*mean score of 5+ on D/T scale for these instruments)*
MHSIP	#26 ("My symptoms are not bothering me as much")
GAF Score	*CSI* data base P-04.0 (from clinician's perspective)

➡ **Desired Outcome:**
Adult clients with SMI are functioning better.

Indicator
Increase over time in the percentage of adult clients with SMI who report having less difficulty with areas of life functioning.

Possible Data Sources:

GAF Score	*CSI* data base P-04.0 (from clinician's perspective)
BASIS-32	Daily Living, Role Functioning Scale, Relation to Self/Others Scale
MHSIP	#20, 21, 22, 23, 24, 25 (various areas of life functioning)

IV. Outcome Domain: Psychological and Physical Health (cont.)

Value:
Because of the many physical illnesses co-occurring with mental illnesses in adults, it is essential that the physical distress that adult clients with serious mental illnesses (SMI) experience should be minimized.

➡ **Desired Outcome:**
Adult clients with SMI are experiencing reduced physical distress.

Indicator 1
Decrease over time in the percentage of adult clients with SMI who report physical health problems.

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Possible Data Sources:

BASIS-32	#19 (difficulty with physical symptoms - such as headaches, sleep disturbances, stomach aches, dizziness, etc.) *(a score of < 2 on this item)*
CA-QOL	#15 (5 categories)
QL-SF	#17 (5 categories) *(a score of < 4 for either of these two items)*

Indicator 2
Increase over time in the percentage of adult clients with SMI who report satisfaction with their physical health (mean score of 5+ on D/T scale)

Possible Data Sources:

CA-QOL	#16a (health in general), 16b (physical condition)
QL-SF	#18 (health in general)

IV. Outcome Domain: Psychological and Physical Health (cont.)

Value:
Adult clients with serious mental illnesses (SMI) should have the opportunity to live life free from substance abuse and misuse (alcohol, street drugs, prescription drugs, over-the-counter medications), drug interactions, and adverse side effects.

➡ **Desired Outcome:**

Adult clients with SMI are experiencing reduced impairment from substance abuse or misuse.

Indicator

Decrease over time in percentage of adult clients with SMI who report impairment resulting from substance abuse or misuse.

Possible Data Sources:

BASIS-32	#28 (alcohol), #29 (illegal drugs) *(a score of 0 = no difficulty, 1 = a little difficulty)*
CSI [3]	P-05.0 ("does substance abuse affect mental health")

V. Outcome Domain: Avoiding Legal Problems

Value:
Adult clients with serious mental illnesses (SMI) have the right to be free from physical and social exploitation and live in a safe and secure environment.

➡ **Desired Outcome:**
Adult clients with SMI are experiencing fewer arrests.

Indicator
Decrease over time in the percentage of adult clients with SMI who report being arrested.

Possible Data Sources:

CA-QOL	#13 (reported in categories of 0 to 6 arrests for last month)
QL-SF	#15c (yes/no for past month)

➡ **Desired Outcome:**
Adult clients with SMI are experiencing less victimization.

Indicator
Decrease over time in percentage of adult clients with SMI who report being victimized.

Possible Data Sources:

CA-QOL	#12a (victim of violent crime in past month, yes/no)
	#12b (victim of non-violent crime in past month)
QL-SF	#15a (victim of violent crime in past month)
	#15b (victim of non-violent crime in past month)

Indicator
Increase over time in the percentage of adult clients with SMI who report acceptable levels of satisfaction (mean score of 5+ on D/T scale) with their safety.

Possible Data Sources:

CA-QOL	#14a (neighborhood), 14b (safe where live), 14c (protection)
QL-SF	#16 (protection they have against being robbed or attacked)

VI. Outcome Domain: Social Support Network

Value:
Adult clients with serious mental illnesses (SMI) should have a satisfying social support network of family and friends.

➡ **Desired Outcome:**
Adult clients with SMI are building effective support networks through increased activities with family, friends, neighbors, or other social groups.

Indicator 1
Increase over time in the frequency/amount of social contacts for adult clients with SMI.
(this will be analyzed for social contacts overall as well as broken down into the two categories of family and friends)

Possible Data Sources:

CA-QOL	#4, 5 (family), #7a, 7b, 7c, 7d (social relations)
QL-SF	#8a, 8b (family), 10a, 10b, 10c, 10d (social relations)

(for both instruments, these are categorical questions -" not at all" to "daily")

Indicator 2
Increase over time in the percentage of adult clients with SMI who report less difficulty with their social contacts (family, friends, social groups, etc.).
(this will be analyzed for social contacts overall as well as broken down into the two categories of family and friends)

Possible Data Sources:

BASIS-32	#7 (relationships with family), #8 (people outside family)
MHSIP	#23 (family), #24 (social situations)

Indicator 3
Increase over time in the percentage of adult clients with SMI reporting acceptable levels of satisfaction (*mean score of 5+ on D/T scale) with their social contacts (family, friends, social groups, etc.).* This will be analyzed for social contacts overall as well as broken down into the two categories of family and friends.

Possible Data Sources:

CA-QOL,	Satisfaction with Family Relations Scale (#6a, #6b)
	Satisfaction with Social Relations Scale (#8a, #8b, #8c, #8d)
QL-SF	#9 (family) , #11(friendship in life)

Attachment 1

Process Indicator: Cultural Competence [5]

Value:
All aspects and functions of the mental health system should be culturally competent and acknowledge and incorporate the importance of culture, language, the value of cultural diversity, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs.

➡ **Desired Outcome:**
Culturally competent services are being provided to adult clients with serious mental illnesses (SMI).

Indicator 1
Increase over time in the percentage of adult clients with SMI from ethnic minorities who report acceptable levels of satisfaction with services (MHSIP items analyzed by race/ethnicity).

Possible Data Sources:

MHSIP Consumer Survey	All questions apply - analyze by ethnicity code (*rate statements as agree or strongly agree*)
CSI [3]	C-06.0 (*Ethnic Codes*)
QL-SF	#23 (family origin codes)

Indicator 2
Increase over time in the percentage of non-English speaking adult clients with SMI from threshold languages who received services in their language of choice.

Possible Data Source:

MHSIP Consumer Survey	#13 - "Staff were sensitive to my cultural/ethnic background." #19 - "I was given written information that I could understand."
CSI [3]	C-07.0 (*Primary Language Codes)*

Notes

1. Outcome domains and value statements are from the California Mental Health Planning Council.

2. SMI refers to the target population of adult clients with serious mental illnesses served by California's public mental health system.

3. If a county is not currently providing this information through CSI, it must report it on a separate face sheet.

4. MHSIP Consumer Survey Short Form (26-item version).

5. Cultural Competence is not considered a separate performance outcome domain by the CMHPC, but rather a process indicator. One of the ways cultural competence can be evaluated may be found in Attachment 1.

RELEVANT CSI CODES

C-03.0	Date of Birth
C-05.0	Gender
C-06.0	Ethnicity / Race
C-07.0	Primary Language
P-02.0	Education
P-03.0	Employment Status
P-04.0	AXIS-V / GAF
P-05.0	Other Factors Affecting Mental Health – Substance Abuse
P-07.0	Other Factors Affecting Mental Health – Physical Health Disorders
P-09.0	Living Arrangement
S-09.0	Principal Mental Health Diagnosis
S-10.0	Secondary Mental Health Diagnosis
S-11.0	Additional Mental or Physical Health Diagnosis

CHAPTER 10
ADMINISTRATIVE ISSUES

Correctly completing each of the performance outcome forms is essential to ensuring the usefulness of the data that are gathered from the Adult Performance Outcome System. In particular, certain parts of each instrument MUST be completed fully and correctly before distribution to the clinician or consumer. This section is intended to provide step-by-step instructions in the form completion and data collection process.

Preparing the Forms

Before the forms are given to the clinician or client for completion, it is critical that the correct *client identification (ID) number, county code, and link date* are entered in the appropriate fields.

- The client ID number is the client's CDS/CSI county client number.
- The county code is the CDS/CSI identification number of the county.
- The link date is what we are using to link sets of forms that were administered to a client at a given assessment. The specific date that is entered in the link date field is not nearly so important as the fact that **the link date should be the same on each instrument for a given administration**. Some counties are using the month and day of the client's intake date as their link date along with the current year (note, the link date year must be the year the instruments were administered). Other counties are using the date that the coordinated care plan was developed. Still others are using the date that the instruments were scheduled to be administered.

Examples of forms with these three fields completed for a hypothetical client are provided at the end of this chapter.

Link Date

On each form (except the *QL-SF*) there is a date field called the "**Link Date**." Completing the link date is critical. The same link date must be entered on both face sheets, the *BASIS-32*, whichever quality of life instrument a county is using and, where appropriate, the *MHSIP* consumer survey. This date, along with client ID and county ID, is used in the linking of forms for any given administration. (*Instructions concerning QL-SF data are on page 10-4*).

It is recommended that clerical staff, **before giving the forms to the clinician** for distribution to the client, enter the scheduled administration date in that field. Again, this indicates the date that the forms were given to the clinician, not the date the forms were actually completed. This date **must** be the same on all of the forms for a given administration time (i.e., intake, annual review, discharge).

Note that, unlike with the Children's Performance Outcome program, the adult satisfaction instrument (the *MHSIP*) should be distributed on the same date as the other instruments (with the exception that this instrument is not administered at intake). This is because the *MHSIP* is much more than a satisfaction questionnaire. It collects a variety of information on perceived outcomes, access to care and service appropriateness. In addition to being useful for program evaluation, this information will be linked to the other outcome instruments to measure the California Mental Health Planning Council's domains.

Instructions Specific to Completing Each Instrument

Client Identification Face Sheet

This face sheet is to be completed only one time. For new clients, this would be at intake. For continuing clients, this would be at the time of their first annual review when the client completes the instruments for the first time.

As noted earlier, a single individual (probably clerical staff) should have filled in the client ID number, county code and link date before the instruments were distributed. These three fields should be the same on each of the outcome forms.

The clinician, or somebody who is very familiar with the client, should complete the rest of the Client Identification Face Sheet. Alternatively, this form could be completed as part of an interview.

The information on the Client Identification Face Sheet includes relatively stable data:

- Client ID Number
- County Code
- Link Date
- Intake Date
- Client Social Security Number
- Client Ethnicity
- Client Gender
- Client Date of Birth
- Client First Initial *(first initial of legal first name)*
- Client Last Initial *(first initial of legal last name)*
- Client's Primary Diagnostic Category
- Does client understand spoken English (Yes, No)
- Does client understand written English (Yes, No)

Supplemental Client Information Face Sheet

The Supplemental Client Information Face Sheet is to be completed at intake, annually, and at discharge. The information on this form will eventually be collected by the Client Services Information (CSI) System. However, the CSI will not be fully operational and stable for a year or more. Therefore, this form, or one that the county creates which collects identical data, must be used until the county is fully compliant with CSI reporting requirements.

As noted earlier, a single individual should have filled in the client ID number, county code and link date before distribution. These three fields should be the same on each of the outcome forms.

Again, with the exception of the client ID number, county code, and link date, either the clinician or somebody who is very familiar with the client should complete the Supplemental Client Information Face Sheet.

Please note that at discharge, one additional question is to be answered: Type of Discharge. Even if the client simply drops out of services, and so, is an unofficial discharge, this should be noted. The reason this information is so critical is because, when evaluating outcomes, it is important to distinguish between those who successfully completed their programs and those who did not.

The information on the Supplemental Client Information Face Sheet includes some stable, linking data and some data which may change over time:

- Client ID Number
- County Code
- Link Date
- Client Current *GAF* Score
- Client's Primary Employment Status
    - Type of Employment
    - If in job market, how many hours per week?
    - If *not* in job market, which category applies (CSI codes)
- Current Living Arrangement (CSI Codes)
- Type of Discharge (completed only at discharge)
    - Self-discharge (Against Medical Advice (AMA))
    - Formal Discharge (AMA)
    - Formal Discharge (Completed Program)
    - Other

Behavior and Symptom Identification Scale (*BASIS-32*)

The *BASIS-32* is a client self-report instrument. It is designed to be self-administered by the client. However, due to functional and literacy issues, the client may require varying degrees of assistance in order to complete the *BASIS-32*.

Before the *BASIS-32* is given to the client for completion, it is critical that the correct *client identification number, county code, and link date* be entered in the appropriate fields. For each client, this information should be identical on each of the forms for a given administration.

California Quality of Life Survey (*CA-QOL*)*

Like the *BASIS-32*, the *CA-QOL* is a client self-report instrument (i.e., it is designed to be self-administered by the client). Again, due to functional and literacy issues, the client may require varying degrees of assistance in order to complete the *CA-QOL*. Our research indicated that most pilot participants were able to complete either instrument without assistance (approximately 60%). Approximately 23% required some assistance. Relatively few participants required total interviewer administration (approximately 15%).

Before the *CA-QOL* is given to the client for completion, it is critical that the correct *client identification number, county code, and link date* be entered in the appropriate fields. This information should be identical on each of the forms for a given administration.

** Note: A county will choose one quality of life instrument to administer – not both.*

Lehman's Quality of Life – Short Form (*QL-SF*)*

The *QL-SF* is also a client self-report instrument, and, similar to the other instruments, the client may require varying degrees of assistance. Again, our research indicated that most pilot participants were able to complete either instrument without assistance (approximately 60%). Approximately 23% required some assistance. Relatively few participants required total interviewer administration (approximately 15%).

The *QL-SF* was formatted by a private vendor and is currently undergoing revision. Currently, specific fields for *client identification number, county code, and link date* either are either not on the instrument, or not in the same format as the other instruments. Counties must still collect these data and then recode if necessary and report them in the format prescribed in the data dictionary.

Before the *QL-SF* is given to the client for completion, it is critical that the correct *client identification number, county code, and link date* be identified with the instrument for later transmission.

For counties using the *QL-SF*, please note:

> *Counties with alphanumeric client identification numbers must put in place a method to replace the numeric codes currently provided on the QL-SF with the appropriate client ID codes as reported to the CDS/CSI.*
> *The MIS number on the form (which corresponds to the Client ID number) does not allow for alpha characters. Therefore, if your county uses a combination of alpha-numeric characters, this MIS number must be reformatted to reflect the identical Client ID number reported to CSI and as defined in the Adult Performance Outcome data dictionary prior to reporting the data to the State.*

** Note: A county will choose one quality of life instrument to administer – not both.*

Mental Health Statistics Improvement Program (*MHSIP*) Consumer Survey

The *MHSIP* Consumer Survey is also a client self-report instrument, but, unlike the other instruments, assistance must not be provided directly by the clinician. This is to assure client confidentiality and encourage honesty. Some assistance in the mechanics of how to complete the form may be provided by clerical staff or peer counselor, including reading the form for clients who are unable to read. However, the actual responses to the questions should be made only by the consumer.

Before the *MHSIP* is given to the client for completion, it is critical that the correct *client identification number, county code, and link date* be entered in the appropriate fields. This information should be identical on each of the forms for a given administration. Additionally, the client should be informed that his or her responses will not be shared directly with the clinician and will only be used for program evaluation purposes.

For All Instruments

The bubbles must be filled in carefully and completely to ensure correct interpretation.